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COMPETITION IN THE MEDICARE PROGRAM

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COMPETITION IN THE MEDICARE PROGRAM

TUESDAY, FEBRUARY 29, 2000

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:10 a.m., in room SD–215, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senators Moynihan, Baucus, Rockefeller, Breaux, Conrad, Graham, and Kerrey.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will please be in order.

Let me welcome everyone to the second in our series of hearings on approaches to strengthen and modernize the Medicare program.

This hearing will focus on how competition between health plans would be structured under the President's reform proposal and under S. 1895, offered by Senators Breaux and Frist.

Both the Breaux-Frist premium support proposal and the administration's competitive defined benefit proposal could significantly enhance the competitive aspects of the Medicare program.

Both proposals seek to create a more efficient health insurance model for Medicare beneficiaries that, over time, could lead to improved health plan choices, affordabilities, and benefits.

Key to the ultimate success of these proposals is their ability to create the information, the incentives necessary to enable beneficiaries to be well-informed and prudent purchasers of their own medical coverage.

It is this prudent consumer behavior that, over time, would allow for slower growth in both beneficiary and taxpayer cost. Equally as important, it could also ease the introduction of needed and potentially expensive benefit improvements such as we are discussing currently with respect to prescription drug coverage.

Today, we will examine two somewhat different strategies to achieve a more competitive Medicare program. The Breaux-Frist proposal links a government contribution to health plans to the average premiums charged by health plans.

The administration proposal links a government contribution to health plans to the premium charged by the traditional fee-for-service plan managed by the Health Care Financing Administration.

Now, these two approaches do reflect different views, as how best to strike a balance between efficiency and equity, and they differ in their particular blend of encouraging plan competition, incentives for prudent purchasing by beneficiaries, and their protection of the premium paid by those remaining in the traditional plan.

I would now like to turn to my good friend and Ranking Member, Senator Moynihan.

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator MOYNIHAN. Mr. Chairman, this is, indeed, a distinguished panel we have on the central subject that we are dealing with in health care, which is the emergence of a market—many markets—but basically competition and how to manage that to the advantage of the largest number. Surely it is a welcome event, and perhaps a predictable one.

What I would say, at the risk of being tedious, is that when you do develop markets you have to look after the provision for public goods, which markets do not provide for—that is why you have governments—the most conspicuous in this case being teaching hospitals and medical schools.

That is a subject which we should address ourselves alongside the provision of insurance for individuals. We are fortunate to have Senator Breaux with us here today, and Senator Kerrey, who are hugely knowledgeable on these matters, and I look forward to the testimony.

The CHAIRMAN. Thank you, Senator Moynihan.

I would now call forward Madeleine Smith, who is Specialist in Social Legislation, Congressional Research Service; Mark McClellan, who is Assistant Professor of Economics at Stanford, and Jeff Lemieux, who is senior economist with the Progressive Policy Institute. It is a real pleasure to welcome this distinguished panel.

Dr. Smith, we would be happy to start with you. Your full statements, of course, will be included as if read. Please proceed.

STATEMENT OF MADELEINE SMITH, PH.D., SPECIALIST IN SOCIAL LEGISLATION, CONGRESSIONAL RESEARCH SERVICE, WASHINGTON, DC

Dr. SMITH. Thank you, Mr. Chairman, Senator Moynihan, Senators, for inviting me to testify about Medicare reform.

My name is Madeleine Smith. I am a specialist with the Congressional Research Service, where I have worked for most of the past 11 years.

I would like to emphasize three points about premiums under current Medicare and reform proposals. First, today all beneficiaries pay the same Part B premium.

Second, the administration and Breaux-Frist reform proposals would allow beneficiary premiums to vary and, thus, introduce greater competition into Medicare.

Third, the two proposals vary in details of how premiums are calculated, but provide similar incentives to beneficiaries to choose lower cost plans.

Under the current Medicare program, all beneficiaries pay the same Part B premium regardless of whether they receive care

under traditional Medicare or enroll in the Medicare+Choice program. The Part B premium does not vary; all beneficiaries pay it and it is the same regardless of where the live.

We know, however, that the costs of providing Medicare to beneficiaries vary. Differences in costs are displayed in Table 1, which shows the average estimated monthly fee-for-service cost by State. In 1999, average monthly costs for Parts A and B ranged from a low of $364 in Nebraska, to a high of $601 in New York.

Because the Part B did not vary and was $45.50 per month in 1999, as it is today, the Part B premium represented a different share of average costs across the States, from 12.5 percent of estimated fee-for-service costs in Nebraska to 7.6 percent in Florida, Louisiana, and New York.

An unchanging, flat, Part B premium, coupled with variable costs of care, means that beneficiaries pay different shares of the cost for the same coverage.

The current Medicare+Choice program fixes minimum beneficiary premiums at the Part B premium rate and allows benefits to vary. Both the administration and Breaux-Frist proposals would allow beneficiary premiums to vary, with the goal of introducing more competition into the program. Under both proposals, in fact, the beneficiary premium could be zero.

The two proposals differ in the way that beneficiary premiums and government contributions to plans are calculated. There are five things to note about the administration's Competitive Defined Benefit Program.

First, a plan's adjusted bid is compared to the average cost for traditional Medicare, with a cut-off at 96 percent of the average. Second, if the adjusted bid is lower than 96 percent of the average, the beneficiary gets 75 percent of the savings and the government retains the remaining 25 percent.

Third, if the adjusted bid is higher than 96 percent of the average for traditional Medicare, the beneficiary pays the entire Part B premium, plus all of the difference in costs. Fourth, a beneficiary who remains in traditional Medicare pays an unchanged Part B premium.

Finally, the government would pay half of the premium for drug coverage for all beneficiaries electing coverage, and provide additional subsidy to those with low incomes.

Table 2 uses a hypothetical example to show how the administration proposal would work. In this example, 96 percent of the costs of traditional Medicare equals $5,760, which is the cost for Private Plan 4.

Note that the beneficiary premium for this plan, $720, equals the beneficiary premium for traditional Medicare. Plans with costs below $5,760 have lower beneficiary premiums and government payments. The first two private plans have a zero beneficiary premium.

The administration estimates that plans with costs at about 80 percent of the average for traditional Medicare would have a zero premium for beneficiaries.

The government contribution increases for Plans 1 to 4. Savings from lower-priced plans are divided between the beneficiary and

the government, with the beneficiary getting 75 percent of the savings and the government getting 25 percent.

Plans with costs above $5,760 have the same government contribution: $5,040 for plans without drug coverage and $5,360 for plans with drug coverage. It is clear from the table that beneficiaries who purchase a more expensive plan pay all of the additional costs themselves. Plan 8's premium bid is $300 more than Private Plan 7's bid, and the beneficiary premiums for these two plans differ by that $300.

The table also shows an apparent anomaly in payment structure. Both Private Plan 6 and Medicare have costs of $6,000. Both are equally efficient in delivering traditional Medicare services.

Yet, under the administration's payment structure, beneficiaries who choose Private Plan 6 will pay more than beneficiaries who choose traditional Medicare, $960 versus $720, respectively.

This difference results from the built-in 4 percent difference in premiums compared. Total costs for the private plan are compared to 96 percent of the cost for traditional Medicare.

I should emphasize that factoring in the geographic and risk adjustment procedures included in the administration's proposal would increase the complexity of the example in Table 2.

In sum, the administration's proposal: guarantees that beneficiaries remaining in traditional Medicare would pay no more than the Part B premium; and allows beneficiary premiums to vary from zero to the Part B premium, plus the entire difference in costs for high-cost plans.

I would like, now, to turn to an explanation of payments under the Breaux-Frist Competitive Medicare Premium System. As in the administration's proposal, payments may vary. Here, they depend on the relationship between the plan's premium bid and the national weighted average premium.

Important points to note are: (1) if the plan's premium bid is less than or equal to 85 percent of the national weighted average premium, the beneficiary would pay zero; (2) if the plan's premium bid is greater than the national average, the beneficiary pays the complete cost of the difference between the bid and the average; (3) all beneficiaries receive premium assistance for the cost of drug coverage included in high-option plans; and (4) low-income beneficiaries get additional financial assistance for the costs of coverage.

Under the Breaux-Frist proposal, all plans, including the HCFA plans, submit a premium bid to the Medicare Board. The board adjusts the premiums to represent the costs for core benefits only, that is, benefits covered under Parts A and Parts B.

This process can be illustrated with the hypothetical example in Table 3. Plans' premium bids are shown in column 2. Premiums for core benefits are shown in column 3. All of the high-option plans, which offer drug and stop-loss coverage, have premiums for core benefits which are lower than the original bids, as does Private Plan 6.

Based on the premiums for core benefits and enrollments in each plan, the board calculates a national weighted average premium, which is $5,896 in this example.

To calculate beneficiary premiums and government contributions, we need to know what 85 percent of this national average is, and

here it is $5,012. Plans with premium bids below $5,012 have a beneficiary premium of zero, and the government pays 100 percent of the plan bid. Private Plans 1 and 2 fall into this category.

Both beneficiary and government contributions would increase until the plan's premium bid reaches the national average, $5,896 here. In this example, beneficiaries remaining in traditional Medicare would pay $811 per year, which is larger than the $720 premium under the administration proposal.

This happens because the premium for traditional Medicare is greater than the national average. This result will occur if most private plans charge less for core benefits than Medicare does.

The maximum government payments in this example are $5,189 for plans without drug coverage, and $5,389 for plans with drug coverage. As in the case of the administration proposal, beneficiaries who choose lower cost plans will face lower premiums. Beneficiaries who choose high-cost plans will pay the entire amount of costs above a threshold.

Under the Breaux-Frist plan, no difference in beneficiary premiums occurs for plans with identical premium bids, such as Private Plan 6 and HCFA Plan 1, both of which have premium bids of $6,000.

Table 3 shows that the beneficiary pays $811 and the government pays $5,189 for both of these plans. There is no difference in beneficiary premiums for plans with the same price as there was under the administration proposal.

This example illustrates that the government is contributing to the cost of benefits not covered under traditional Medicare, a situation that occurs under some Medicare+Choice plans today, but would not occur under the administration proposal.

In sum, the Breaux-Frist proposal does not guarantee an unchanged Part B premium for beneficiaries who remain in traditional Medicare and, as in the administration proposal, allows beneficiary premiums to vary.

Comparing these two hypothetical examples indicates that, on average, beneficiaries would pay slightly more under the Breaux-Frist plan, $899 per year or 15 percent of the total, compared to $860 or 14 percent of the total under the administration proposal.

This is due to the way the premiums are calculated, not anything intrinsic to the proposals. The computational formulas could easily be altered to change the results.

To summarize, both proposals would make significant changes to the Medicare program by allowing beneficiaries' premiums to vary and the two proposals differ in their treatment of premiums for beneficiaries remaining in traditional Medicare.

This concludes my testimony. I would like to thank the committee for this opportunity to discuss these two proposals to reform Medicare.

The CHAIRMAN. Thank you, Dr. Smith.

Now, Dr. McClellan.

[The prepared statement of Dr. Smith appears in the appendix.]

STATEMENT OF MARK McCLELLAN, M.D., PH.D., ASSISTANT PROFESSOR OF ECONOMICS, STANFORD UNIVERSITY, STANFORD, CA

Dr. McCLELLAN. Thank you, Mr. Chairman, Senator Moynihan, Senators of the committee, for the opportunity to address you today about competition in Medicare. From 1998 to 1999, I served as Deputy Assistant Secretary for Economic Policy in the Treasury Department, where I assisted in the development of the President's proposal for competitive Medicare reform.

I would like to emphasize that my comments today are my own views.

I am also a practicing physician in the Department of Medicine at Stanford Hospital, where we treat a large population of Medicare beneficiaries. Hardly any of these visits go by without reminding me of the importance of modernizing the Medicare program and making it more efficient.

Medicare needs to become more competitive so that it can rely less on regulation and more on innovation to increase the value of Medicare services. Both the proposal of Senators Breaux and Frist and the President's proposal would reduce regulation in favor of price competition and other modernizing reforms modeled on the best practices of the private sector.

Many private employees, as well as Federal employees, have benefitted from such competitive approaches. These reforms will help Medicare catch up.

As a physician responsible for the health of many Medicare beneficiaries, I am also aware of the potential risks of sudden and significant changes in the program. Medicare needs to change substantially, but for the sake of beneficiaries, must do so carefully.

One way to view the President's proposal is as a safe foundation for competitive restructuring of Medicare, a way to implement competitive reform, while continuing to guarantee that beneficiaries can enroll in the traditional Medicare plan as they do today.

At least two key conditions must be met to have effective price competition among all plans in Medicare, including the traditional plan. First, private plans must be allowed to bid competitively against the traditional plan and each other, that is, to set their own total premium.

Second, beneficiaries must pay more or less when they choose a plan that costs more or less. Plans can attract beneficiaries by offering lower costs for higher quality, or both.

You have already heard about how both proposals allow Medicare to meet these conditions. Under both proposals, private plans are paid a total amount that they bid themselves, not a regulated price.

Under both proposals, the government pays for, or supports, a portion of the total payment to a plan. Under both proposals, the beneficiary premium is set so that beneficiaries pay less for less expensive plans and more for more expensive plans.

A key difference between the proposals, is that under the President's proposal the beneficiaries payment for traditional Medicare is determined the same way it is today. Government payments to all plans are tied to costs in the traditional Medicare plan, in contrast to the average cost of all plans in the Breaux-Frist proposal.

I want to emphasize that this difference does not insulate traditional Medicare from competition. If private plans are able to provide benefits at a significantly lower cost compared to traditional Medicare, or if traditional Medicare's costs rise faster than the costs of private plans, then beneficiaries can lower their premiums by choosing the lower cost private plans, a choice they do not have in the current system, and the government would share in these savings.

Beneficiaries would have strong, new financial incentives to leave traditional Medicare for the more efficient private plans. Thus, traditional Medicare faces real price competition, even though its premium is protected. The President's proposal, like the Breaux- Frist proposal, would reward beneficiaries for choosing the plan that is the best value.

Although both proposals seek to use price competition in Medicare to generate cost savings and values for beneficiaries and the government, the President's proposal is likely to give a larger share of the total savings from competitive reform to beneficiaries and a smaller share to the government. This is because the traditional Medicare plan is likely to cost more than the average plan.

Consequently, in the President's plan, the government would provide a higher level of support for traditional Medicare, and also a higher level of support for the premiums of private plans. Thus, the savings to beneficiaries through lower premiums are considerably larger.

My written remarks have a more detailed discussion of the difficult issue of geographic adjustment of government payments to plans. The President's proposal uses full geographic adjustment of private plan payments to allow private plans to compete effectively against traditional Medicare in high-cost areas. It also includes a hold harmless provision for areas with below-average costs.

I have focused on price competition. This is only one of the critical elements needed to achieve effective competition among all plans in Medicare. Also needed, is continued improvement in the methods for adjusting Medicare payments based on a beneficiary's health, so that plans have just as much incentive to compete for Medicare many chronically ill beneficiaries as for the healthy elderly.

Effective competition also requires the provision of better comparative information on health plans to beneficiaries, especially better information on health plan quality, and a fair and well-run process for choosing plans.

All of these considerations suggest that competitive reform will be challenging and will take time to implement, and that it should not be expected to yield large, short-term savings. Even in the long run, it should not be expected to solve Medicare's financing problems.

But competitive reform can give the program new long-term strength by allowing Medicare to use competition to help assure that beneficiaries and taxpayers are getting high value from Medicare spending and by enabling the program to avoid the heavy reliance on regulation that has impeded its ability to adapt to a changing health care environment.

The substantial consensus on the basic features of competitive reform that is reflected in the Breaux-Frist proposal and the President's proposal provides clear directions for giving the program long-term strength.

Thank you.

The CHAIRMAN. Thank you, Dr. McClellan.

Mr. Lemieux?

[The prepared statement of Dr. McClellan appears in the appendix.]

STATEMENT OF JEFF LEMIEUX, PH.D., SENIOR ECONOMIST, PROGRESSIVE POLICY INSTITUTE, WASHINGTON, DC

Dr. LEMIEUX. Thank you, Mr. Chairman. Thank you, Senator Moynihan, Senators, for inviting me to discuss how to change Medicare's system for competition.

In the last decade, I have worked for HCFA, and for a long time for the Congressional Budget Office, and then with the Bipartisan Medicare Commission chaired by Senator Breaux, and now with the Progressive Policy Institute.

In those positions, I have heard—and we have all heard—many valid reasons for considering changing Medicare's competition. We have heard that we should try to prevent Medicare from overwhelming the Federal budget when the baby boom generation retires. We have heard that it would be nice to move Congress more out of the micromanagement business in Medicare and more into the oversight business.

We need to stabilize Medicare's still-shaky platform for private plan options, and we all know that it is important to add essential new benefits, especially for prescription drugs and for out-of-pocket protections.

But I believe there is an even larger issue standing behind some of those reasons, and that is this. The economy in the United States and the health care sector have changed a great deal since Medicare was originally designed.

I believe, to maintain strong political support from all of its stakeholders, beneficiaries, taxpayers, health care providers, well into the future, Medicare should be retooled for that vibrant, new economy.

The new economy is based on research and innovation, information and empowerment, market forces, and self-adapting, self-improving, non-hierarchical organizations. In the future, seniors and taxpayers alike, accustomed to the efficiency and transparency of other sectors of the economy, will demand more value from Medicare as well, better benefits, more choices, competitive premiums.

As the Balanced Budget Act and its aftermath have shown, it is very difficult for a central authority—in this case, Congress—to micromanage a health system as vast as Medicare in such a fast-paced economy and health sector.

So the question then becomes, how should Medicare be managed for better benefits at reasonable costs? The answer, I believe, is through innovative new premium schedules. Both the President's proposal and the Breaux-Frist-Kerrey plan, would use beneficiary power through those premium schedules to create value.

The Breaux-Frist proposal also goes the next step by attempting to build a self-improving and self-managing system for Medicare, consistent with the principles of the new economy.

Because we cannot know now what the best policies will be in the future, the Breaux-Frist plan concentrates more on process building than on detailed policy making. I think it will take several years of hard work to build a new entity to supervise the new competitive system for Medicare, and it will also take time to build a new mentality, a new, more business-like mentality, among the people who operate the government-run fee-for-service plans.

To gain the political support it needs, the public must be confident that Medicare is fair, modern, responsible, and transparent, and I believe this sort of process, this well-designed system of planning and reporting, will help with independent evaluation, analysis, and outside comment, and that will help the public and you, its elected representatives, to gain that confidence in Medicare change.

Finally, Medicare is so large and important that proposals to modernize it should be designed to, first, do no harm. In the Breaux-Frist proposal, if the new competition does not save much money, then Medicare's costs and beneficiaries' premiums would be determined by the government-run fee-for-service plan, just as under current law.

If the new high-option plans, either public or private, are slow to get going, slow to ramp up, then beneficiaries would only have a spotty opportunity to choose from comprehensive plans with comprehensive benefits, the same sort of opportunity they have now.

The new premium formulas in the Breaux-Frist proposal are specifically designed to protect taxpayers, whether the proposal works well or not, and with the proper calibration, beneficiaries should not notice any unusual change in their monthly premiums when the new formulas are put in place.

Now, to be sure, I think that the new Medicare will exceed expectations. I think that competition will restrain both costs and beneficiary premiums compared with current law, and I think there is a good chance that high-option coverage will quickly spread nationwide, and that all seniors will be able to choose from reasonably-priced comprehensive plans, either public or private.

But if I am wrong about all that, Medicare would default to its current status, limiting the risk of change. Given Medicare's importance, I think limiting the risk of change is a very important consideration.

Now, I have concentrated on limiting the risk of change if the proposals did not work as well as planned. I know that the committee has also heard concern about what would happen if the proposals worked better than planned and saved more money, slowed the growth of Medicare spending more than expected in the first year or two.

I believe that those sorts of problems are much easier to solve. If the system works better than expected and we save more money than we think, then we should be able to solve the transition problems seamlessly.

So to sum up, I think that Medicare's sustainability will rest on its ability to adapt to the new economy. I think that beneficiary

choices, in a fair and competitive system, driven by premium schedules like those introduced by Senator Breaux and his colleagues and the President's plan, should drive Medicare into the future.

I think that building a process for continuing improvements is more important than getting all the policy details right this year, and I encourage the committee to create a system that would, first, do no harm if economists like myself are wrong in our initial projections.

Thank you very much.

The CHAIRMAN. Thank you, Mr. Lemieux.

[The prepared statement of Dr. Lemieux appears in the appendix.]

The CHAIRMAN. Let me turn to you, Dr. Smith, if I may. In the last few years, Medicare has had a problem, as you know, with private plans pulling out of a Medicare+Choice program. In your analysis, did you find anything in these two proposals that would make these plans more or less likely to pull out of the Medicare program than is current, and is one proposal more likely than the other to reduce plan pull-outs?

Dr. SMITH. Senator, as you know, a number of plans have withdrawn from the Medicare+Choice program over the past few years. In fact, in both the 1999 and 2000 contract years, about 13 percent of the contracts were not renewed. Many plans have argued that insufficient Medicare+Choice payments were the reason for withdrawal, or reduction of service areas.

Both reform proposals would allow plans to bid the premiums that they believe are necessary to cover Medicare-covered services. They will both eliminate the government-set premiums. To the extent that insufficient payments were the cause for withdrawal and the instability in the program, both reforms would fix this problem.

The Breaux-Frist proposal would also level the playing field between private plans and traditional Medicare by requiring all plans to face the same premium calculation method. Because of this difference, the Breaux-Frist proposal might stabilize the program more.

It is likely that both reform proposals would increase private plan participation in Medicare, and as the number of private plans increase, the programs may attract some plans that withdraw a few years after joining the program, due to insufficient resources, poor planning, or perhaps a design that included the intention to leave after a few years.

Given this possibility, HCFA or the Medicare Board, whatever the administrative apparatus is, must have procedures to ensure that beneficiaries have some alternative if their current plan fails to renew and remain in the program.

The CHAIRMAN. Let me ask you this, Dr. Smith. Both of these proposals remind me somewhat of our work with the Federal Employees Health Benefit Program. Which of these two proposals would you say is closer to the Federal Employee plan?

Dr. SMITH. Well, both of the proposals have similarities and differences to FEHBP. Both of the two reform proposals would establish a competitive structure that is very close to that in the Federal program.

There is no competition among plans in FEHBP, nor would there be under the two reform proposals, to enter the system. All plans that meet a minimum requirement would be allowed to participate, as they are allowed to participate in FEHBP.

Where the competition occurs, is among plans for enrollees. During an open season, the potential enrollees select a plan, and that is where the competition enters the programs. Under FEHBP and both of the Medicare proposals, risk would be shifted to private plans.

There are, however, some differences between FEHBP and the Medicare reform proposals. Under FEHBP, there is no minimum or standard benefit package that plans submit bids for. FEHBP provides a variety of benefit packages to Federal employees and annuitants.

Under both Medicare reform proposals, the plans would at least have to provide some minimum set of benefits. Indeed, under the Breaux-Frist proposal, plans could offer expansion to this minimum benefit package that they would include in their original bid to beneficiaries.

OPM, under FEHBP, controls the level of benefits offered to plans to some degree by restraining their ability to increase benefits, to provide a very rich benefit package, making them, if they increase some benefits, decrease other benefits in order to prevent adverse selection in the program.

The authorizing legislation for FEHBP also does not include a description of benefits covered under the program, whereas under both of these proposals I presume at least Medicare Parts A and B coverage would be outlined in the legislation.

Given these considerations, I think both of the reform proposals would make moves to look like the competitive structure offered under FEHBP.

The CHAIRMAN. Thank you.

The next question I would like to ask is to both of you gentlemen. Let me say this. In studying these two approaches, they seem to reflect a policy balance between encouraging plan competition and protecting the premium beneficiaries pay to remain in the traditional HCFA-run plan.

Would you explain some of the rationales for arriving at the particular balance found in each of these proposals? We will start with you, Dr. McClellan.

Dr. MCCLELLAN. Senator, let me start by, again, saying that this is my opinion and not the views of the administration. But certainly in my view, at least initially, the President's proposal seems like the most prudent approach to competition.

About five out of six beneficiaries are enrolled in the traditional program today, and most of them have had no experience with private Medicare plans, and no experience with comparison shopping for plans.

The approach the President outlines allows the option of continuing in traditional Medicare without new premium increases until beneficiaries feel confident enough in their understanding of their new opportunities for lower premiums, and perhaps higher value coverage, in the more efficient private plans.

My expectation is that, if private plans provide as good or better benefits at lower cost, it will not take too long before many beneficiaries feel confident enough to switch.

So there is a strong amount of competition in this proposal, but let me be very clear about what the costs of doing this are. In one respect, the President's proposal does not quite create a level playing field with private plans.

Dr. Smith mentioned that the premium is the same in the traditional Medicare plan as for a private plan that costs 4 percent less. This 4 percent discount in the payments of private plans is a reflection of current law, in which private plans receive discounted payments compared to traditional Medicare.

It was presumably included in the proposal, for reasons of fiscal prudence. If you suddenly got rid of this discount and beneficiaries did not respond with even more movement into the lower cost plans, then Medicare expenditures would rise.

However, if competition works and a significant number of Medicare beneficiaries do move into less costly plans, then Medicare spending should fall enough to make it possible to reduce, if not eliminate, this discount in payments.

The second thing that it costs you, as I mentioned in my testimony, is more savings for beneficiaries at the expense of somewhat less savings for the government. You could do a similar kind of thing with the Breaux-Frist proposal, as Dr. Smith mentioned.

Instead of setting the limit on government contributions at something like 88 percent of the cost of an average plan, if you upped that to 91 percent or so, then there would not be as noticeable of an impact or as much potential for an adverse impact on the premium in the traditional Medicare plan.

But that would mean that the payments to all plans, the traditional Medicare plan, all the private plans, would be a little bit higher. The payments by the beneficiaries would be a little bit lower.

Beneficiaries would still be paying more for a more expensive plan and less for a less expensive plan, it is still price competition, but it would be more in the flavor of the President's proposal, which generally keeps the government level of support a little bit higher; still some government savings, but not as much as under the Breaux-Frist proposal.

The CHAIRMAN. Dr. Lemieux?

Dr. LEMIEUX. I think I would only add to that to say that both proposals, the President's and the Breaux-Frist proposal, both create competition and they both would maintain and try very hard to improve the HCFA fee-for-service plans.

I think that sometimes these sorts of competitive proposals are positioned in terms of winners and losers, but I think there is a very strong chance that we will have winners and winners in this sort of thing, with both the private plans searching for efficiencies and a newly-formed, more forward-looking, more business-like HCFA fee-for-service plan, finding new and innovative ways to compete and allowing those to prove themselves in the marketplace.

Just to reiterate what Mark was saying, the Breaux-Frist plan goes right to a level playing field, but I think its sponsors are open

to the idea of some transition systems to make sure that there are no big changes in beneficiaries' premiums in fee-for-service or private plans.

The President's plan never quite gets to a level playing field, but I think that there is openness to discussing moving in that direction over a period of time. So, the approaches may have a different emphasis at first, but I think they are working in the same direction in many ways.

The CHAIRMAN. Well, last week we had witnesses suggest that we start with the administration's proposal and then later move more into the Breaux-Frist. Does that make sense to you, gentlemen? Do you want to start, Dr. Lemieux?

Dr. LEMIEUX. Sure. I do not know if it is a question of starting with the administration's proposal and then moving in the direction of Breaux-Frist. I think that that is the general idea, that maybe you should start with the Breaux-Frist proposal, except with some transition guarantees along the lines of what the administration has proposed, to make sure that there is no sudden change in the fee-for-service plans' premium on implementation. That would sort of be my idea.

The CHAIRMAN. Dr. McClellan?

Dr. MCCLELLAN. Senator, I think there certainly are some attractive features of that idea. What I would emphasize, is that, as you all know, it is very hard to tell what issues are going to be facing the Medicare program 3 years, 5 years ahead, let alone further ahead than that.

Almost certainly, in undertaking as fundamental a change in Medicare as making it a truly competitive system, there will be some needs for retooling along the way. Sure, it may turn out to be the case that private plans offer generous, low-cost benefits to all types of seniors, those with many chronic illnesses, as well as those who are relatively healthy, and we will have no problems with a Breaux-Frist-type proposal down the road.

On the other hand, it may well be the case that the traditional Medicare plan can keep its rate of growth lower than many private plans, at least in many areas of the country, and might end up being a very important long-term option to keep affordable for beneficiaries.

I think it is just very hard to say now which of those situations is likely to emerge with any certainty, and for that reason I think the best way to view Medicare reform today is that we need to get started down this path.

We need to get started down this path while there is not an impending fiscal crisis, while there is an opportunity to take some considered steps that do not need to generate a large amount of savings and that can really focus on strengthening the program for the long run. We will almost certainly have to make some course corrections further along the way.

The CHAIRMAN. My time is up.

Next on the list is Senator Breaux.

Senator BREAUX. Thank you very much, Mr. Chairman, for holding this hearing. I was wondering whether all of your Republican colleagues were in Virginia handing out ballots or something. [Laughter.]

The CHAIRMAN. I hope so.

Senator BREAUX. I did not say for who. [Laughter.]

Well, thanks once again for having this hearing, and thank our panel for their discussion.

I think that some of the comments I would really agree with, in the sense that both of the proposals from the administration and that contained in Breaux-Frist tries to move to a competitive market and brings about more competition.

I think that, while there are some differences in how we do it, I do not think the differences are necessarily irreconcilable. There is a lot of common ground about how we both approach going to a competitive system.

I mean, the real problem with the current system now in Medicare+Choice is that it is not any real competition. Medicare+Choice is reimbursed based on the fee-for-service price, and you have got all the private plans competing and HCFA is isolated.

How bad that is, is if the private plans could offer the benefits for a lower price, the beneficiaries do not get to pay a lower fee. I mean, that does not make a lot of sense. The only thing they can do is offer more benefits.

So it is not working, and it is not too difficult to understand why it does not work. But I think that this is a big improvement, and I think that, while we have differences, they are not irreconcilable in this particular area.

So, having said that, Mark, you did a great deal of really good work in developing this, and I know that. I was wondering, we have proposed creating a Medicare Board to supervise the competition between HCFA and the private plans, so that you do not have one of the competitors supervising the competition, but you have an outside board looking at it and saying, all right, what can you offer these benefits for, or what can you offer these benefits for, and negotiate.

Do you have any thoughts about that concept?

Dr. MCCLELLAN. Yes, sir, Senator. I think, first of all, the points that you raised are critical ones for assuring that competition is effective. This is, the management of the competition process is not a passive one, it is not one that can be done simply by regulation.

It is one that involves active outreach to beneficiaries, active collection of information, and presentation of that information in a fair way to all plans, and in a comprehensible way to beneficiaries. It is vitally important that whatever organization oversees the competitive process, has expertise and objectiveness in doing so.

It also seems like it would be a good idea, as we move toward more competitive systems, for the Health Care Financing Administration to get the benefit of outside expert, private sector, and other advice, people who are very experienced with implementing these kinds of systems in other health care purchasing contexts.

That said, I am a little bit concerned about the long-term feasibility of a board that is somehow completely independent from the Executive Branch, from HHS, and from Congressional oversight.

I think you all heard last week from Robert Reischauer some skepticism about whether Congress and the administration, given the political sensitivity of the issues involved in Medicare, and as

we just talked about, the need for some retooling along the way as we continue to revise this competitively restructured program, I think you heard from him some skepticism about the ability of a system that is designed for Congress and the President to stay at arm's length to really work that way effectively.

So it might be better in thinking about this to think about some kind of mechanisms that could achieve the goals that we just described that would not necessarily be independent of the Executive Branch or HHS, but could still achieve those goals that you described. I think we need some further thinking on that.

Senator BREAUX. I would not want the board to be under the jurisdiction of HCFA. HCFA will be one of the competitors. I mean, I think it would be unfair to have one of the teams that are competing to be subject to what are the competitors. Surely they would be subject to oversight by Congress. I mean, Congress is not going to walk away from overseeing the Medicare program.

Let me ask, Jeff or Mark, or even Dr. Smith, if you could comment on the concern that Senator Conrad and others have expressed about rural areas and trying to get competition into rural areas.

If you are going to have the fee-for-service program competing in rural areas you may not have a lot of private sector competition in these areas, so what we try to do, is to say that they would never pay more than the national weighted average in those areas.

Can either of you comment on protections for individuals in those areas under what Breaux-Frist talks about?

Dr. LEMIEUX. Even before we consider special protections for people in those areas, I am not convinced that private plans would not consider competing in those areas, necessarily.

Senator BREAUX. They get reimbursed in a different fashion than they do now.

Dr. LEMIEUX. In the Federal Employees' plan, even in the most rural areas, there are still several choices of fee-for-service or PPO, preferred provider organization, plans.

I think that, properly structured, the Breaux-Frist, the President's plan, could entice those sorts of plans to also serve wide regions of the county, not just cities where the HMOs have most of their business.

On the protections, the Breaux-Frist plan says that a beneficiary in an area where the only choices are the HCFA-sponsored plans, either the standard plan or the new ones with high options, that they would never have to pay, in effect, more than they would have had to pay under current law.

Senator BREAUX. Under the fee-for-service plan.

Dr. LEMIEUX. Yes.

Senator BREAUX. All right.

Senator, thank you.

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman.

As I listen to all of this, all three of you, a little sense of mind is that, in some sense, these are all helpful. They are good ideas to "reform" Medicare in some way. But a couple, three things still linger on the horizon for me, and one is solvency of the trust fund.

You all mentioned that, to some degree, there might be some savings, but you are not pinning a lot of hopes on a lot of savings here, as I read between the lines.

With the boomers starting to kick in in 2011—in my State, for example, the number of senior citizens will double in 25 years—it just seems to me that, although this is not the precise forum here, we have got to spend a lot more time thinking about the solvency of the trust fund.

I know the President suggests about $400 billion, a third of the on-budget surplus, for the trust fund, something I think that we have to give a lot of thought to.

Second, is the point we just touched on, and that is access. There was one managed care plan in Montana that pulled out. I am not convinced that either of the two plans are going to sufficiently encourage managed care to go into rural areas.

The Federal plan does not cover Nebraska, for example, totally. It does not. In my State of Montana, barely. I think that we have got to figure out much more solidly how to solve that part of it, if you are going to get broad-based support for either of these two plans.

Finally, the question of quality. I think we owe it to ourselves to spend a lot more time addressing risk adjustment to avoid risk selection of patients. I still have this feeling that, even with these two plans, that a lot of plans are going to try to get the most healthy, they are going to try to make some money here.

I am not sure that they are going to really reach out to the chronically ill, which comprise by far the bulk of Medicare expenses. I do not see what is here to force that.

Eighty-five percent of American seniors are not under managed care today, so how are we going to get the 85 out there? I wondered what thoughts you have on how to better address risk adjustment so we tend to work against adverse selection or risk selection of trying to find the most healthy patients.

The one thought I had, was some kind of a pilot project, demonstration project, some kind of partial capitation, where part of the payment is capitated and the other part would go to those plans that do have the sickest patients or outliers, if you will, or something to try to address that part of the problem.

So let me talk with you, Dr. Smith, on how these plans are going to solve the access and the quality problems that occur in rural areas, particularly, and for the chronically ill. Forty-five percent of Medicare expenses, I think, are in the last 5 years, or 80 percent of the expenses are in 10 percent of the population.

Dr. SMITH. Yes. I think that the first point to note about the access question, is that competition is expected to increase because some plans are able to offer lower premiums than they currently are today.

That would provide incentives, I do believe, to beneficiaries to shop around for plans. If they can pocket some savings from their choice of Medicare benefits, I believe that will provide incentives to shop.

As far as risk adjustment is concerned, I agree with you that it is a very serious problem that deserves a lot of attention. The proposals for reform could fail if risk adjustment is not appropriate.

Efficient plans, if not appropriately risk adjusted, may look inefficient and be driven out of business without appropriate adjustments to their premiums.

Senator BAUCUS. My time is expiring. Dr. McClellan, could you address that question, please?

Dr. MCCLELLAN. Senator Baucus, I certainly agree with your concern. I think your idea about experimenting with partial capitation in risk adjustment is a good one. There also are some good ideas out there to build on the fact that most of what we know about risk adjustment is about risk adjustment using fee-for-service data, not using managed care data, and not collected in a way that makes sense from a managed care perspective as opposed to a fee-for-service perspective.

Accompanying competitive reform, it might make sense to include a substantial amount of funding or support for experimentation with a range of methods to improve risk adjustment. It is an absolutely fundamentally critical issue to making sure competition works well for seniors.

Senator BAUCUS. So what do you suggest? What do we do? How do we address, in a more solid way, access and quality?

Dr. MCCLELLAN. There are good proposals out there, like ones for partial capitation, that have not yet been tested on senior populations extensively. There are good proposals out there for how to collect risk adjustment types of data in managed care organizations that just do not have the same kinds of fee-for-service data collection structures that have been used in many of the risk adjustment systems to date.

This could be done now. I think most of the plans on the table are not ones that would be implemented tomorrow, they would be implemented several years down in the future. Developing better risk adjustment methods could be an important part of laying a foundation for assuring that competition is implemented effectively.

Senator BAUCUS. Thank you.

Senator BREAUX. Could we get Dr. Lemieux, if he has a comment on that question?

Dr. LEMIEUX. Well, sure. I would like to just make two very quick points on that. The Breaux-Frist plan leaves open the risk adjuster, that we could use some sort of pooling arrangement or partial capitation. That is one of the options that the board was given or instructed to look at.

I also think that when we talk about quality, it is very important to get patients, beneficiaries, information. Not just information about their rights and so on, but information about which doctors, which hospitals, and which providers are the best and do the right thing, what their comparative success and failure rates are, complication rates, and so on, and so forth.

I think a well-run Medicare Board or other entity running Medicare, even though this might not be its number-one job, could serve a very important purpose in spurring the development of that sort of information and spreading it to beneficiaries to allow them to help themselves.

Senator BAUCUS. I appreciate that. That is a great theoretical response, but as a practical matter, people just throw up their hands. You get lots of different competing benefits plans.

Dr. LEMIEUX. My wife is a health care practitioner and she has told me, yes, that is very good, and that would help a lot of my patients. But some of my patients are dumb as a rock, and what do I do about them? They will still require health plans.

Senator BAUCUS. I do not think it is fair to say "dumb as a rock." There are just a lot of people who have a hard time figuring all this out.

Dr. LEMIEUX. Right.

Senator BAUCUS. And I am one.

Dr. LEMIEUX. Me, too.

The CHAIRMAN. Senator Conrad?

Senator CONRAD. Thank you, Mr. Chairman, and thank this panel. It has been an excellent panel.

I would like to go back to the issue that I raised in the last hearing, something that Senator Breaux has commented on, Senator Baucus has commented on, that is a very, very real problem.

We cannot just paper over it, because there are some of us who represent rural areas and we are not going to be satisfied until we are assured our people are going to be protected. I am not assured, so far, that they are going to be protected.

Under the administration's plan, I have some confidence because in that circumstance, if you are in fee-for-service, you are not going to be in a situation in which your rates get jacked up dramatically. Under the plan of Senator Breaux and Senator Frist, there is a real risk.

I am struggling to find a way to change that plan, modify that plan, because much of that plan, I think, makes a great deal of sense. In fact, I think both of these plans are moving in the right direction. We need competition. That is going to improve, I think, the results that we get.

But let me go back to the fundamental problem with Breaux-Frist. In my State, there is no managed care. None. Zero. Our average cost in Medicare is $378 per patient. The national average, Dr. Smith, you noted, $520. $520 nationally, North Dakota, $378.

Now, there is not much room for somebody to come in under that. There is no—I repeat, there is no—competition. So my people are not getting the benefits of the extra benefits that people are getting in some Medicare choice plans.

They are not getting prescription drugs, they are not getting eyeglasses, they are not getting hearing aids, they are not getting other things that people who have additional options have available to them.

And it is not just true in my State. I am not just talking about North Dakota. Nationally, only 24 percent of those in rural areas have Medicare choice available to them. In urban areas, it is 86 percent.

I mean, this is a chasm. We talk about the digital divide, we have got a medical divide that exists in this country and it is only going to get worse if we do not guard against having two classes of patients in America.

Now, Senator Breaux says very well that they provide protection, not having to pay more than the average weighted 88 percent of the national weighted average. But that protection goes away if managed care, even one plan, comes into your State. Now, we could

have one plan come in and just be in Fargo, North Dakota, or at least have a significant majority of their people in Fargo, ND.

Then the rest of the folks would be in fee-for-service and fee-for-service could rise dramatically because they would be left with the sickest, the least healthy. That is the concern I have.

Dr. McClellan, you have come up with a competing plan, an alternative plan. Do you understand the concern I have about Breaux-Frist, and do you have an idea of how it could be fixed?

Dr. MCCLELLAN. Well, as you mentioned, in the President's plan, the plan developed by the administration, there is this safety net of the traditional Medicare program with the premium determined in the same way it has been in the past.

To the extent that better private plans do enter rural areas, I think there would be stronger incentives for them to come in now under this reform than there are under current law because of their ability to set their own premiums, and so forth.

But I agree with you, that based on the past experience, it would be at least a bit of a leap of faith to assume that we should probably start there, and that is why one of the main advantages of the President's plan is to give this initial safe haven for people who want to continue in the traditional plan.

I would also like to emphasize, as Jeff Lemieux mentioned, that there would be some changes within the traditional plan itself to help it modernize, to help it contract with preferred providers, to help it do some other things to deliver higher-quality care within a fee-for-service setting.

Many fee-for-service plans in the private sector are also working on developing such arrangements—there are point-of-service plans and other kinds of arrangements like that—that might work well in rural areas.

If you just have one hospital and several doctors, as I know that you do in many of the smaller communities in North Dakota, there is not necessarily a whole lot that a managed care plan can do. But there is a whole lot that could be done through better organization of the doctors with the hospitals, referral relationships, things like that.

The kind of management flexibility that is included in the President's plan and in the Breaux-Frist plan might help provide an alternative to relying on managed care alone for improving quality of care in rural areas.

Senator CONRAD. I would just make a final comment, if I could, Mr. Chairman.

I think we have also got to be dealing with more fundamental reform. Frankly, if you look at rates of reimbursement under Medicare for different parts of the country, if you go to Mercy Hospital in Devil's Lake, North Dakota on a heart attack and look at the rate of reimbursement versus Mother of Mercy Hospital in New York City, it is a 100 percent difference. A 100 percent difference. The same is true if somebody has pneumonia, a 100 percent difference.

With the advent of technology that costs the same everywhere, with the advent of what it costs to attract a doctor which is becoming increasingly the same across the country, we cannot stand a 100 percent differential.

The CHAIRMAN. Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I want to start out with a point that I ended up by making last time. Actually, I did not end it up, it was the only time I spoke. That is, that I think the important thing here is to try and work a solution which the Finance Committee can agree on.

I am not satisfied with the Breaux-Frist plan, I am not totally satisfied with the President's plan. On the other hand, I do not understand all of it as well as I need to because it is more recent, but they both create reform, and I think we have to agree on that when we start.

One question I would like to ask, I guess, Dr. Smith, of you. If Medicare is now running at a percent more efficiently than private plans, and if we can expect an average of over the ensuing years of about 1.5 percent greater increase in private plans than Medicare, and if we assume for the moment, Dr. McClellan, that the President's plan does, in fact, have reforms in it and that fee-for-service is held exactly where it is for those who do not go into the private market, how does one make the point that the private plan route holds out promise, particularly when you put it in the context of what Kent Conrad just said, and that is that in rural areas—I mean, we have a plan. We actually have two plans; one of them is close to bankruptcy, the other is, I guess, all right, but involves just a smaller part of our State.

We have no margin for error. We cannot take risks. Max, Kent and I cannot take risks on this because it is too dangerous in a rural State. There are too many under-served areas, too much fee-for-service emphasis right now.

Why does it make sense to assume, in that the President's plan also has some competition and that, therefore, the Medicare costs could potentially go down, why does it make sense that we reach out for the private plans other than the fact that that is what the American entrepreneurial spirit likes to do? Obviously, that is what the private plans want to do.

What is the rationale policy-wise for doing that?

Dr. SMITH. The rationale for increasing the incentives of private plans to join the program?

Senator ROCKEFELLER. Yes. When we already know that Medicare is cheaper and more efficiently run, and that its prospects for being even more efficiently run over the coming years are definitely there, particularly if the President's plan does have the reforms which I believe it may have?

Dr. SMITH. I do not believe that over time it has been shown that Medicare consistently grows at a slower rate as far as inflation of costs for delivering the same kinds of services.

I do not believe that consistently over time Medicare has been shown to be cheaper. I do believe, in the past few years, the rate of growth in Medicare has been below that of the rate of growth in premiums for private plans.

Senator ROCKEFELLER. So that may speak less about Medicare and more about the cost of private plans.

Dr. SMITH. Or the difference between the two. I do not think that it is clear that savings can be generated through Medicare alone,

and competition, I would hope, would yield greater efficiencies for both private plans and Medicare.

Senator ROCKEFELLER. All right. Well, we have not connected entirely, but I just want to establish the point that, at least in recent years, Medicare has been cheaper. And I agree with Kent Conrad's point also, that Medicare is not nearly as good as Medicaid, it is no golden rule, although it is there and people think that it is the standard.

The next thing I would like to ask, Dr. McClellan, is to you. That is, that if I am not wrong—and John, you tell me if I am—when you get to 40 percent of the cost of Medicare combined, trust funds, in the general revenue fund, there is a cap. Then the appropriations process administers the rest of the money.

Now, we have seen in FAA in recent years—which has not very much to do with this hearing—a real reluctance on the part of appropriations, and the Budget Committee, for that matter, to put out the money necessary to keep our planes from, they estimate in 20 years there will be a major accident every 7 to 10 days because the appropriators are not putting out the money because they would rather spend it on something else, and there is no great public outcry, which there ought to be.

Now, health care. What comfort level do you feel about saying, we are all right up to 40 percent, but after that, if we get there, it is the appropriations process that we have to rely on. That makes me nervous, and I would like to find some way to work with that so that we can come to some kind of a compromise.

But could you comment on that?

Dr. MCCLELLAN. Sure. I would be glad to. And I certainly do not want to put words in Senator Breaux's mouth or represent their views on this aspect of the Breaux-Frist proposal.

My sense is that, like some of the other issues we have discussed today, there is some room for compromise and that the underlying concern is just that we make sure we get as high value as possible out of the dollars that we spend on Medicare.

The kinds of competitive reforms that we have talked about today, the restructuring of the traditional Medicare program that I think you all are dealing with in other hearings, in part, as well, I think would all contribute to that idea.

My own advice on this issue would be that a discussion like we are having now, when we are not up against an accounting limit of some kind but can really have a fundamental discussion that focuses on what is best for the program in the long run, how do we get the most out of the dollars that we are spending on Medicare, is a much more effective way to go about this debate.

I think the accounting kinds of limits are helpful, but I do not think that should deter us from trying to undertake quite significant fundamental Medicare reform now that builds on the ideas of the Breaux-Frist proposal and the President's proposal.

Senator ROCKEFELLER. Mr. Chairman, I just have to say that Dr. McClellan did not comment on my question, that is, the belief that the appropriators would make up the necessary difference. I question that. I am worried about that, based upon a lot of experiences, including the Federal Aviation Administration.

Dr. McClellan. I have to just beg a little bit of ignorance about the exact details about how this appropriation process would work when the 40 percent limit is hit.

But I do applaud the interest among most or all of the members of this committee in thinking hard about Medicare financing in the future, down the road, and about taking steps to make sure we are getting as much value for our money as possible.

We are spending a lot on Medicare now, and we are going to be spending a lot more in the future, and these issues of assuring a high-value program are going to get even more important and this is a terrific debate to have.

The Chairman. Senator Graham?

Senator Graham. Thank you, Mr. Chairman.

Again, I commend you and Senator Moynihan for holding these series of hearings. I think it is important that we put today's hearing in context. The title of today's hearing is a hearing on competition in the Medicare program.

1999 was a year of massive retreat from competition in the Medicare program. In fee-for-service, for instance, we had a very successful demonstration project in how competition in bidding for disposable medical equipment could not only save money, but increase the quality and access of participants. That program was scrapped in 1999, no more competitive bidding for DMEs.

In the area of managed care, we had provided, in 1997, for competitive bidding for managed care. We were inching towards implementing that program. That was not only scrapped in 1999, but a prohibition imposed against even considering competition in managed care for the next two or 3 years.

So what was the result of that? The result of that, and other steps taken in 1999, is that we also lost a year of solvency in the Part A Medicare program, so we killed the most promising competition initiatives and reduced solvency in 1999 as the sum result of all of our efforts.

So we are taking up the issue of competition in the Medicare program against a very bleak recent background of our serious interest in competition in the Medicare program.

With that background, it seems to me that, if we are serious about competition, that we have got to start with the question of, what kind of a Medicare program do we want to have, and then how do we use Medicare to help us get to that objective?

I am concerned that there is a temptation to say that we are going to keep the Medicare program that we have got today and then try to impose competition as some magic pill that will alleviate its problems.

As I said at our last meeting, I think two of the principal maladies of the existing Medicare program are outgrowths of its historical context in the 1960's and earlier.

Those are, first, its orientation on acute care, particularly to the detriment of prevention, and to some degree the detriment of chronic care, and second, the fact that it is based on the premise that people die shortly after they retire, whereas, we know today that the average American female will live 20 years after 65, and the average male 15 years. We are dealing with an aging process, not the event of death.

Any fundamental reform of Medicare must deal with those two issues, movement away from the focus on acute care towards chronic and preventive care, and treating the process of aging as a continuum rather than a single event of death shortly after 65.

So my question is, what will the President's program, in terms of Medicare reform, do to get us back on track of serious reform, to put the train that was derailed in 1999 back on the tracks? Second, what will it do in terms of reforming Medicare on these two issues of acute versus prevention and chronic care, and a process of aging rather than an event of death?

Dr. MCCLELLAN. Senator, I guess I will start answering that question. As you know, the demonstration project on competitive bidding for durable medical equipment is one of a number of elements that is included in the part of the President's plan that deals with modernizing the traditional Medicare program.

I could not agree with you more that the program today is a bit stuck in some of the institutional features of the 1960's and 1970's, when it was brought into existence.

I think that just underscores the need to move away from the kind of very tight microregulation of what goes on in this program and to more flexible management structures for the traditional Medicare program just like exist in private plans today.

Competitive bidding for durable medical equipment, centers of excellence, selective contracting with high-quality providers to provide better care; all of these are ways in which the traditional Medicare plan can move from being a program that really is stuck in a little bit of an outmoded way of financing care for disease into something that is much more appropriate for today's medical care. Just think about what care is going to be like 30 years from now. If you think people are living a long time today, let us wait another 30 years.

If you think there are a lot of medical treatments that can help them live better today, just wait a little bit longer and the problems will only be compounded, which is a reason to start moving in this direction now.

Senator GRAHAM. As one who is 63, I would not expect these problems to be——

Dr. MCCLELLAN. No, you have got a lot more years. You have lots more years.

The only thing I would add to that, is if we are going to move away from regulation, I think the comfort level of a lot of economists and other experts with the program would be higher if we did have an outstanding competitive system to fall back on.

If HCFA is going to have a substantial amount of discretion in managing the traditional Medicare program, which it frankly needs for all of the reasons that you mentioned, I think many people would feel more comfortable about that if there were effective alternatives that people could turn to if they thought HCFA was not providing high-quality, low-cost care for them. That is why I see these programs, the competitive reform program and the modernization program, as both essential pieces of a fundamental Medicare reform.

The CHAIRMAN. Next, is Senator Moynihan.

Senator MOYNIHAN. Thank you, Mr. Chairman. I was called away for a moment.

Just one sort of plaintive comment, and I hope that they might have some response. None of these wonderful witnesses even mentioned hospitals, which is where doctors come from, I think. Is that not right, Dr. McClellan?

Dr. MCCLELLAN. Yes, Senator. I actually practice in a teaching hospital.

Senator MOYNIHAN. Yes. At Stanford.

Dr. MCCLELLAN. Yes. Yes, sir.

Senator MOYNIHAN. How are things going? [Laughter.]

Dr. MCCLELLAN. Things have been better. I have to say that we are not looking to the kinds of Medicare reforms that we have discussed today, either restructuring the traditional Medicare program or improving competition in private plans, to help us do the kinds of things that we think are an essential part of improving America's health care system for the future.

There is a substantial amount of research that goes on at Stanford, a substantial amount of teaching. My experience is, and I have not been a doctor for that long, but just over the last 5 years that I have been at Stanford, you can see things getting tighter and tighter as competition increases, as the pressures from the traditional Medicare program on everything from billing to amounts reimbursed for specific services become tighter.

What I am always surprised by is just how much effort many of the clinicians are still willing to provide to teach students, even though it takes out of their time that they really need to be doing, even though their incomes are being squeezed and their opportunities for research are being squeezed as well.

You mentioned at the outset that competition and reform, at least as we have been discussing so far, do not take care of the public good aspects of the American health care system. I think that is a critical element that we need to pay increasing attention to as we rely more and more on effective systems for competition.

We may do a very good job of getting high-quality care provided to Medicare beneficiaries at a low cost at a point in time, but if we are not also making investments in future treatments to further improve the health of these beneficiaries, in education of the future practitioners who will care for these beneficiaries, we are missing a critical part of the picture.

Senator MOYNIHAN. I much agree. I do think it has to be addressed. While we are thinking of introducing competition into what was very much a state-run proposition when we started it in 1965, we might consider some independent mode of financing medical teaching and clinical work.

This committee, in 1994, on a bipartisan vote, 12 to 8, voted out a health care bill, which would have covered 95 percent of the population and included a premium, we called it a tax, of 1¾ percent, on all health insurance policies, 1.5 percent to go to medical schools and teaching hospitals and the other 0.25 percent to research. This would have been a tremendous event.

The administration had proposed to us a health care plan which was going to solve the costs of medicine. They proposed to cut the number of doctors and the number of specialists.

The theory was that specialists are rich people who practiced on Park Avenue or in Silicon Valley, and treated people who are socially superfluous or are undeserving. Now, that was what your government wanted to do. Dr. Smith, is that not correct?

Dr. SMITH. I am sorry, sir. I do not remember that. [Laughter.]

Senator MOYNIHAN. Dr. McClellan?

Dr. MCCLELLAN. I do not remember that policy either.

Senator MOYNIHAN. I will just interrupt to tell you why: we went through Lexus nexus and found that there were four entries from the New York Times and the LA Times on this. Nobody knew it was there. We knew, and I think they knew, but nobody else knew. But that is where we find a proposal to control costs by rationing supply. Very brutal. Would you think we should cut the number of specialists in half?

Dr. MCCLELLAN. Is that a question directed to me, sir?

Senator MOYNIHAN. Yes, sir.

Dr. MCCLELLAN. No, sir. I am not sure that we know what the right number of specialists is, and I would much prefer to rely on methods like competitive approaches and seeing what kind of health plans emerged to do a better job.

Senator MOYNIHAN. Please see what turns up in research and what interests people, and let science and knowledge make its way. I leave you this thought. I will take the liberty of sending you a copy of our bill and the analysis with it, and tell you that it got to the floor of the Senate and was rejected as totally inadequate by the administration. As usual, we got nothing. Nothing. A lesson? Well, whatever.

But we will take the liberty, and I would appreciate if there would be any commenting. The Progressive Policy Institute is good on comment. [Laughter.]

Dr. LEMIEUX. Sometimes too good.

Senator MOYNIHAN. As is our Congressional Research Service.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator BREAUX. Mr. Chairman, could I have a follow-up question?

The CHAIRMAN. Yes, Senator Breaux.

Senator BREAUX. I thank the panel. I just wanted to ask one other question. I think when we were talking about risk that Senator Rockefeller raised, and I think also Senator Baucus, there is no question, anything we do, we should try to minimize the risk to the people who benefit from the program. That is a given and I totally agree with that.

I would suggest, however, that the real risk that we face is not in looking at a new system to deliver health care services for our seniors, but rather the real risk is staying in a current system without any changes, a system that barely covers half of the needs of the average beneficiary, a system that is $7 billion in the red this year and has been every year since 1992.

I think that we cannot continue without a great deal of risk to continue to cut providers, nursing homes, hospitals, doctors like we did in BBA 1997 and do not know whether we are going to put anything back in it or not.

I mean, that, I think, is the real risk that we have facing us, and which is a greater risk in trying to move to a new system that can be designed for the 21st century.

Let me ask a question. Assuming that we may not be able to get everything done in this Congress or in any one Congress, can you comment on the feasibility or possibility of, say, just thinking out loud, the concept of establishing a Medicare Board, which Medicare Board would run a prescription drug program, which Medicare Board would also be responsible for running a Medicare+Choice program, and a Medicare Board which would oversee competitive demonstrations in a couple of States around the country.

Is that something that you can move towards, and yet get some results and get some information from to determine whether the next step can be made or should be made? Any comments on that? Yes.

Dr. LEMIEUX. Yes, sir. I think that those sorts of process improvements are doable and that would be very helpful. I think that sometimes we have a tendency to focus on objective and design and to exclude consideration of process as not being quite so important.

But I think, working toward a system where everyone is comfortable, where health providers, where members of Congress, the public, are comfortable that the competitive changes are going to work well, it is very important and we can work a long way in that direction this year and next year, and very soon.

I think, to add one item to your list, I would consider it a very helpful process improvement focusing HCFA on operating the fee-for-service plans as well as possible and getting started that planning process whereby they would try and work out a business plan for running a more efficient fee-for-service plan.

Senator BREAUX. Mark?

Dr. MCCLELLAN. Senator, I certainly agree with you that the real risk is staying with the current system, which, as Senator Graham pointed out, is just plain out of date. Steps that we can take now, short of enacting these major reforms, would be helpful.

I would also point out the importance of developing some of these specific ideas to help modernize the traditional plan and developing some specific ideas for thinking about how competition would work and whether alternative delivery forms might work in rural areas, would be good ideas to add to your list.

Senator BREAUX. Dr. Smith?

Dr. SMITH. The only thing I would add, Senator, is that the design of the board is probably of importance, and who is responsible for overseeing the board's activities should be examined.

Senator BREAUX. Thank you very much.

The CHAIRMAN. We will be holding hearings on governance in the near future.

Well, I want to thank the panel for being here today, for excellent testimony. We will continue to call on you for future recommendations and advice. Thank you very much.

It is now my pleasure to call upon Len Nichols, who is a principal research associate of the Urban Institute; Keith Mueller, who is director of the Nebraska Center for Rural Health Research; and the third is Karen Ignagni, who is chief executive officer of the American Association of Health Plans.

It is a pleasure to welcome you. As you know, your full statement will be included as if read. We call, first, upon you, Dr. Nichols.

STATEMENT OF LEN M. NICHOLS, PH.D., PRINCIPAL RESEARCH ASSOCIATE, URBAN INSTITUTE, WASHINGTON, DC

Dr. NICHOLS. Thank you, Mr. Chairman, Senator Moynihan, and members of the committee. I am honored to come before you today to discuss proposals that could enhance the role of competition in Medicare.

I was asked to draw upon my research as a health economist, as well as my experiences as a member of the Competitive Pricing Advisory Commission, the CPAC, which Senator Graham mentioned before. As you know, the CPAC was created to bring about competition and we have been thwarted in our goals, and we can talk about that later, if we can.

Mr. Chairman, both proposals before us today are commendable. They are comprehensive, logically cohesive, and they share three key features. They recognize the centrality of prescription drug coverage, they create price incentives for both health plans and beneficiaries, and they protect our most vulnerable beneficiaries. In my view, combining elements of both of these plans could get us very close to significant and desirable reform.

I would suggest we consider that there are five goals for a reformed Medicare health plan system. The first goal, is to reveal the true cost of delivering high-quality care efficiently.

We cannot really know as a society what we want to buy if we do not know how much it costs. Both proposals are based upon competitive bidding by health plans, which is a major improvement over today's administered formula system. However, both plans could improve on this score.

The Breaux-Frist plan does not require all insurers to bid on identical benefit packages. Most private sector practitioners of managed competition do use common benefit packages to facilitate comparison shopping and to eliminate risk selection by benefit design.

Now, I understand the attraction of benefit package freedom, but it turns out we could obtain the competitive advantages of standardized packages without dictating every jot and tittle from Washington or Baltimore.

For example, the Breaux-Frist framework, Congress could specify the actuarial value of the standard drug benefit and let local area stakeholders work out the details of their standard drug benefit. This was the approach taken by the CPAC, and I can assure you, local beneficiaries dearly love getting to have a say in what their drug benefit would be.

The Clinton plan does have almost common benefit packages, but I fear the Clinton's plan reference premium in high-cost areas might be too high. Clinton fully adjusts for current geographic cost differences. That is, including input prices and all utilization differences, which in effect pegs the benchmark government payment very near the current local cost level.

Now, Clinton does allow beneficiary premiums to fall as plans bid lower than the benchmark, but some areas of our country have utilization today that is so far above the national average, bene-

ficiary premiums would hit zero before all the utilization difference was exhausted.

Therefore, it is unlikely that premiums of plans in these high-cost areas, precisely where potential savings from competition are the greatest, would ever get to be as low as their true costs could be.

Now, in my view, goals two and three can be combined because they are about providing incentives for health plans to become efficient and incentives for beneficiaries to choose those efficient plans.

Incentives are implemented through payment rules which have two basic tools: carrots, advantages from offering low prices, and sticks, disadvantages from offering high prices. Breaux-Frist uses both tools, whereas Clinton uses only carrots.

The Clinton team argues, as Mark did eloquently, that carrots are enough, and some good economic theory is on their side. However, the practical experience of employers is not. Until large employers set defined contributions so that workers had to pay more to stay in their self-funded fee-for-service or loose PPO plans, HMO market shares remain fairly small in this country.

The fourth goal, is to protect beneficiaries from the consequences of geographic, income, and health status differences. There are many issues here, but I will focus on geographic adjustment, which is among the larger conceptual differences in these two approaches.

Recall that Clinton's adjustment is full, input price plus utilization, while Breaux-Frist only adjusts for differences in input prices. In a way, Breaux-Frist reflects the view that there is one efficient standard of care and the government should not subsidize any utilization above that average.

Clinton's approach is more agnostic about the locally efficient standard of care. His plan expects any real inefficiencies to be eroded by his carrots over time. Now, Breaux-Frist may be right, as an analytic matter, in the long run; economists, unlike doctors, cannot really say a priori.

But it could make beneficiaries, providers, and health plans in high-cost areas rather unhappy to learn this fact very quickly, which gets us to the last goal, which is to provide for a relatively smooth transition from the current system to a new, more efficient one.

This is a dimension where the Clinton plan really shines, for it is in many ways a perfect transition plan. It holds fee-for-service beneficiaries harmless, while imparting gentle but real incentives for plans, including, importantly, fee-for-service Medicare to become more efficient.

In essence, Breaux-Frist is less patient. The first year's national weighted average could introduce quite a price shock in some high-cost areas of the country which would, indeed, part strong incentives, but add a real cost to beneficiary and plan stability in those areas, and perhaps in the political popularity of reform itself.

I would like to emphasize that either approach can easily be modified to achieve what we want, a more efficient Medicare program. One could start with Clinton and then reduce the degree of geographic adjustment over time, while gradually loosening the ties between fee-for-service costs and the beneficiary reference price. Al-

ternatively, you could start with Breaux-Frist and just transition to the use of the benchmark national weighted average.

I would suggest, given imperfect risk adjustment at the moment and a strong preference for fee-for-service on the part of many current beneficiaries, however, it is probably wise to move towards such an efficient system slowly. Nevertheless, I would encourage you to do so.

My statement is focused on pricing incentives because that is the core analytic issue in the proposals at hand, but virtually all policy observers agree we cannot reform Medicare and ignore quality.

A practical system of information flows about quality of care that beneficiaries, their families, and plans believe in must be created and maintained. A new Medicare pricing system that ignores quality will never maintain the support of the American people.

Finally, it is worth reminding ourselves that competition is not a panacea in and of itself. Competition in any health insurance market, especially one for our most vulnerable citizens, must be very carefully structured and the competing objectives of efficiency and equity must be balanced.

Still, I believe a properly structured competitive health plan market can be the Medicare program's best long-run friend, serving both beneficiaries and taxpayers quite well. I applaud your quest for that balanced structure and would now be glad to answer any questions.

Thank you very much.

The CHAIRMAN. Thank you, Dr. Nichols.

Dr. Mueller?

[The prepared statement of Dr. Nichols appears in the appendix.]

STATEMENT OF KEITH MUELLER, PH.D., DIRECTOR, NEBRASKA CENTER FOR RURAL HEALTH RESEARCH, OMAHA, NE

Dr. MUELLER. Chairman Roth, members of the committee, thank you for this opportunity to comment on the implications of Medicare change for our rural beneficiaries.

My testimony today reflects the work of the Rural Health Panel of the Rural Policy Research Institute, or RPRI, and is consistent with a lot of the policy positions taken by the National Rural Health Association. The specific words, of course, are my own.

I am going to focus on the rural implications of the current proposals in the context of rural beneficiaries, and then rural delivery systems.

Currently, Medicare beneficiaries in rural areas do not have the same kind of competing health plans available to them as their urban counterparts. Despite the best efforts of you and others in Congress to level the playing field between rural and urban areas, prospects for rural beneficiaries have not brightened since the BBA of 1997, and in many places they have dimmed because of withdrawals from rural markets.

Rural beneficiaries are not, in large numbers, benefiting from Medigap plans that include the full range of potential benefits. In short, if there is a prototypical Medicare beneficiary to keep in mind when trying to improve this program, that person lives in a rural community.

The Medicare Preservation and Improvement Act, S. 1895, assumes that multiple plans, some of which would parallel current managed care plans that offer expanded benefits at reasonable cost, would be available to all beneficiaries.

As you have heard, that is based somewhat on the experience of the Federal Employees Health Benefit Plan, but that plan demonstrates that there would be choices available in most areas, but the choices would not include expansive managed care plans.

Remote areas such as Rushkill, NE have not attracted managed care plans, and in such places there may be only one national insurer that includes local providers on its panel. When a plan includes a community in its service area but none of the local providers are included in its preferred provider panel, that is not a viable option for most elderly residents of the community. In brief, competition is not coming any time soon to such areas.

Now, the legislative proposals offer high-option plans in those areas by saying the government-sponsored plan would always offer a high option, but that could become costly to rural beneficiaries.

The adjustment for 88 percent and holding them harmless at that rate in S. 1895 becomes void if there is only one other plan offered in the area. That could be a plan, again, whose preferred providers are located elsewhere. The President's proposal takes a similar approach, but in the context of savings for the beneficiaries.

Rural beneficiaries could eventually see an increase in their costs for premiums for two reasons. First, unless the guarantee of 12 percent of the weighted national average is completely effective, beneficiaries will pay more for the government-sponsored plan.

Second, since the premium for the core benefit plan is set as a single national premium, beneficiaries in low-cost rural areas would be subsidizing those in high-cost urban areas.

I do have some suggestions for improving this part of the legislation. One, recognize the difficulties in established competing insurance plans with different benefits and premiums. The assurance to beneficiaries regarding personal liability for premiums should be based on the presence of competing plans using local providers, not simply any competing plan.

Two, plans most likely to be responsive to the local needs and also likely to continue are those based in local areas, such as we have now in Bend, OR or Rugby, SD. Starting such plans has been difficult because of initial spikes in utilization by beneficiaries who previously delayed some treatments, commonly cataract surgery.

A potential remedy is to invest in locally-based plans by allowing for an initially higher government contribution that would phase out within, say, 18 months.

Three, the government-sponsored fee-for-service plan should vary premiums by region of the country rather than having a single national premium. This approach would be more consistent with allowing the new government plan to be more competitive within the service areas of other plans and would have the effect of more accurately pricing premiums in rural areas.

To move to the effects on the rural infrastructure, rural health care providers have spent the last 2 years trying to cope with the payment restrictions in the BBA of 1997. The Refinement Act of 1999 has provided some relief, and what we have done primarily

is to deal with the reality of rural provider difficulties through special payments.

Those payments become threatened as we move to a competitive system. Aggressive purchasing behavior by all plans serving Medicare beneficiaries could pose problems, provider panels may not include local providers, providers included in the panel 1 year may not be included the next, payment to providers may be reduced, and current special payments may be threatened.

Some suggestions to deal with that: (1) health plans could be required to contract with local providers in remote rural areas, perhaps based on Medicare payments; (2) health plans could be required to continue all current special payments and classifications affecting rural providers; (3) the government-sponsored plan could be required to continue special payments, subsidized if necessary so it is not reflected in premiums; (4) the government policy could set a minimum price structure below which no health plan would be allowed to negotiate; and (5) Medicare payment could be used to invest in locally-based health plans by offering bonus payments during early months.

In closing, there is a lot of work to be done around any of these proposals, and I want to thank the committee again for the opportunity to testify this morning and to say that the RPRI panel certainly is available to you at any time, along with other rural health researchers, to try to deal with a lot of these details.

The CHAIRMAN. Thank you, Dr. Mueller.

Ms. Ignagni?

[The prepared statement of Dr. Mueller appears in the appendix.]

STATEMENT OF KAREN IGNAGNI, CHIEF EXECUTIVE OFFICER, AMERICAN ASSOCIATION OF HEALTH PLANS, WASHINGTON, DC

Ms. IGNAGNI. Thank you, Mr. Chairman, members of the committee. It is a delight to be here to share the experiences of health plans.

I want to communicate that our community is prepared to work very closely with you. We want to be part of the solution. We think we have made some important contributions, many important contributions, for beneficiaries and I am going to talk about some of those today.

Where I want to start is where I want to end. Our best advice to the committee is that the vision of the long term needs to guide what you do in the short term.

That will be relevant for how you consider the matter of prescription drugs, how you consider whether there is a need for additional Balanced Budget Act relief—I believe there is—and the need to proceed with some other changes that have been put on the policy table with respect to other aspects of the program.

I would like to deal with two issues this morning. First, is to go back to Senator Rockefeller's conversation, which is why are we having this discussion? I think it is a very provocative matter and I would like to hit it head on.

I think the most important reason to have this discussion is not what we have discussed up until now this morning, it has nothing

to do with payment, it has nothing to do with competition, it has everything to do with beneficiaries.

The Institute of Medicine has just released one of the most important studies in health care in a number of years, and maybe the most important study in health care, period.

It has indicated that the 1965 chassis, the way we used to think about health care in an unorganized, unintegrated way, is not the best way to achieve improvements in patient safety.

As we think about the Medicare program and the challenge before us, clearly, systems approaches that are offered in health plans, provider-based systems, other systems across the country, offer some real opportunity, not only to deal with the issues we have discussed thus far today, but, I would submit, a much more systematic and deep concern. Such as how do we assure not only that this program will exist for the baby boomers and beyond, but how do we assure that the care that people get will be safe?

So I think it is an important element that has been thus far overlooked, but I think is very relevant to the discussion you are about to have, both today as well as in the future.

Second, why do this? Competition in the private sector has offered the opportunity for many low-income beneficiaries who do not otherwise have coverage that supplements fee-for-service Medicare to achieve benefits such as cost containment protection, catastrophic protection, and other important benefits that they cannot get elsewhere.

This is an important issue we should not overlook as we talk about the economics, as we talk about the architecture of change. It is about the beneficiaries. There have been some important contributions here that I think should be looked at very carefully.

Now, how do you get here? First, if we believe that we need to move in the direction that has been contemplated either under the President's proposal or under the proposals offered by Senators Breaux and Frist, then I think one of the most fundamental issues before you is to have the discussion about stabilizing the current competitive program, Medicare+Choice.

What we have done, is we have retrofitted this program on the 1965 chassis. There have been major contributions by this program for beneficiaries which they find very valuable in survey after survey, and we need to look very closely at this.

We think that this platform offers you an opportunity for taking the next step to think about reform, but without resolving the problems of Medicare+Choice will only be an elusive goal.

Second, we think that it is time to talk about options for prescription drug coverage that are in sync with this concept in Medicare that we have had of universality, but that are also in sync with where you want to go in the future with Medicare restructuring.

We would urge you not to consider options that take you off course from this long-term objective, and would be delighted to talk about how you get there, what that means, and specifically some proposals.

Third, let me conclude by mentioning where I started, which is, the vision of the long term should guide what we do in the short

term. We believe that the Congress should maintain a core level of benefits for Medicare beneficiaries.

There has to be a choice between Breaux-Frist and the President's proposal with respect to providing a safety net. We think there are ways to look at the Breaux-Frist proposal and provide a safety net within it to respond to many of the concerns that you have laid out here this morning, and elsewhere.

We believe that beneficiaries should be given choices, that the contribution should not disadvantage beneficiaries who seek to explore other delivery systems outside of the traditional delivery system—other delivery systems that may be more appropriate for them.

We think that you need to have a level playing field, which we have talked about for many years but have never achieved in Medicare with respect to regulatory uniformity. Finally, we think that there needs to be a safety net for beneficiaries as you transition into a new program.

In conclusion, Mr. Chairman, we are pleased to offer these thoughts. I chose not to repeat what we have given to you in our testimony in an effort to respond to some of the questions to be helpful to the committee. We believe where you start is critical. We have strong views about how you start, what you do, based on the very real experiences in the private sector thus far.

Thank you very much.

[The prepared statement of Ms. Ignagni appears in the appendix.]

The CHAIRMAN. Thank you.

Dr. Nichols, can you speak to what we really know about competitive systems? What can we learn about competitive systems from private sector experience and research?

Dr. NICHOLS. Well, Mr. Chairman, I think there are two lessons I would like to highlight, and one actually comes from our attempt to implement competitive pricing for managed care plans through the CPAC. That can be summarized basically as: overpayment is popular.

I think our fundamental problem was that, in those high-cost areas where we wanted to do the competitive experiments, beneficiaries today are getting great benefit packages from the efficiencies that managed care delivers and they cannot do anything to give them price cuts, so they give them drugs, they give them vision, they give them hearing, they give them other things. So, the beneficiaries like what they have got.

The plans saw competition just among themselves and not among fee-for-service as inherently unfair, so they were worried about what would happen. And the provider said, let me get this straight. You want to lower payments to plans? I do not think I am going to gain from this.

So by the time we were able to get to the representatives of those areas and explain why this was important, every single constituency was uniformly against it. We did not have a very easy time, I would say.

So I would say, overpayment, on average, is popular. That does not mean you cannot do anything. The fundamental thing I would offer, is to remember that the most important variable for the sol-

vency of the Medicare, the future of the Medicare program, is the rate of growth of cost per beneficiary.

That rate of growth is much more important than the level of cost in a given year. Go back and look at what those objections were. They were worried about losing their drug benefit, basically, let us get down to it.

You have a solution before you, that is, to put drugs into the package. I would submit, if you put drugs into the package and design a program around the schemes we have talked about, you could get, over time, enough savings from real competition to perhaps pay for a lot of that extra cost, and that might be a way to buy acquiescence to the reform. So the first lesson is, we have got to deal with that reality on the ground.

The second lesson is, from the private sector, I would say, a number of us have kind of made noises about quality, but there has been no real concrete discussion of quality.

There is a tremendous amount of exciting work going on by private employers in the quality field. In particular, General Motors and the Business Healthcare Action Group in Minnesota, both of which use quality scores on different plans, worked out with both plans and providers, and the premium offered by the plan ties beneficiary premiums to those scores. They basically give the beneficiary, the employees, information about the quality scores.

Now, Medicare probably does not want to go as far as to say, we are going to tie payment to plans based upon some quality score which we might still be arguing about, but what you might do is something we did talk about in the CPAC context, and that is, set up a quality pool where you have maybe 2 percent of the premium to go into a pool, and that 2 percent is allocated to plans based upon agreed-upon quality scores.

That 2 percent could grow over time to 5, 10, or whatever turned out to be useful, but a way to link real incentives to provide quality as opposed to just kind of talk about it. I think both of those lessons are important.

The CHAIRMAN. Dr. Mueller, would you expand on your idea of regional premiums, discussing the advantages and disadvantages of such a move?

Dr. MUELLER. One of the advantages, is aligning the fee-for-service or the government-sponsored program payment with the concept of competition within market areas that drives a lot of the non-government-sponsored plans. So rather than having a single national rate adjusted, however perfectly or imperfectly for geographic differences, you allow the rate to vary by natural market or service area.

An advantage of that for rural beneficiaries, for example, is it would align more closely with the pricing structure and utilization that somewhat exists in a rural area.

A disadvantage would be that you are eliminating the sort of pooling of all of the dollars into the national pot for distribution back out through that fee-for-service payment system, and on the rural side sometimes that can achieve everything the plans are designed to.

That could actually have a positive impact if plans paid more out to providers as a result of having a slightly higher premium than they otherwise would in a perfectly competitive market.

But, on balance, it is a way of saying that we want the premium that the beneficiary pays pegged as closely as possible to the cost of providing care to that beneficiary in the area in which they live.

The CHAIRMAN. Let me ask you, Ms. Ignagni, last year Senator Moynihan and I sent a letter to you and other prominent representatives of the health insurance industry, as well as prominent members of the pharmaceutical industry. We asked your two industries to begin a dialogue on workable options for a Medicare prescription drug benefit.

Can you give us a brief progress report?

Ms. IGNAGNI. Yes, sir. I would be delighted to. We had a meeting—in fact, we hosted the meeting at AAHP—and everybody attended, all the CEOs of those organizations that you wrote to, as well as their chief staff policy group. We had a very thorough and in-depth discussion about the future of Medicare and where prescription drugs fit in.

I do not feel that I am at liberty to talk about the views of any particular constituency that is not ours, but I will tell you, in general, there was broad consensus about the elements of what you are talking about here today in terms of the long-term restructuring.

There are some differences of opinion about how you do prescription drugs, where you start, in what context you do it, et cetera, and we will continue to be discussing those issues with the members of the group that you asked to be put together.

We will also continue to have these discussions with members of the senior citizen community and others who care very deeply about how you resolve these questions.

Our board, speaking for AAHP, met yesterday and passed a resolution about the need to provide prescription drug coverage. We have provided some principles for the committee's consideration and we hope they will be helpful.

But one of the most important discussions that I believe occurred around that table yesterday was the idea that you need to know where you are going to decide how to develop the prescription drug recommendations.

That is to say, if you want to move in the direction of thinking differently about Medicare, assuring beneficiaries a safety net, having more competition, allowing beneficiaries to see the advantages of that in a way that people under 65 do, then you need to think about prescription drugs in that context in developing proposals that fit with those models.

So we would like to be helpful to you as you consider these specifics and the general theories of where you want to go, what you want to do this year. We think we have an important contribution to make and we are not going to shrink from that. The board talked about this for a great deal of time, and I would be delighted to share it with you at an appropriate time.

The CHAIRMAN. When do you think you will have specific recommendations?

Ms. IGNAGNI. Well, we have some now. We are talking about the notion—if you allow me, if it is appropriate, just to describe it briefly—that beneficiaries should have a contribution to move across the various sectors of health care and choose the delivery systems that are most appropriate for them.

There is no community more than health plans that have witnessed firsthand the value of the integration of prescription drugs in the regular medical care package. It has worked for our beneficiaries. Our colleagues on the previous panel talked a great deal about the efficiencies of dealing with those with chronic illness in a coordinated setting with prescription drugs.

You cannot handle chronic illness without prescription drugs, we well know that. We have worked very, very hard wherever possible to provide prescription drugs, so we think we have some important lessons to share.

People like to have choices, they like to have different delivery system alternatives. We should maintain that principle. We should provide some flexibility so plans can, in fact, provide different benefit packages, think about an actuarial equivalent number and then ask plans, challenge plans, to provide benefit packages that allow beneficiaries to choose what is right for them. I think that is a good system. Our people feel that that could be very useful.

We also think it is important to recognize that the individuals who are at the lowest level of the economic spectrum, many of whom are in our plans, do not have the resources now to purchase this on their own. So we need to think about special assistance for individuals who are greatly in need.

The CHAIRMAN. Well, my time is up. I just do want to say that we would be very interested in what your organizations see as workable options for providing prescription drug benefits.

Ms. IGNAGNI. I might say, Mr. Chairman, in response to that, we had a great deal of discussion about the difference of opinion that seems to be out there with respect to various choices. We are hoping that our proposal could help bridge some of those differences. We offer it with that in mind and we hope that it will be helpful.

The CHAIRMAN. Senator Moynihan?

Senator MOYNIHAN. To persist and to thank Ms. Ignagni and the group that is working on this matter, because we do look forward to it, but to ask the panel—and I do not know if this is a practical suggestion or not—is there any possibility that we could get some metric about the increasing role of pharmaceuticals in medical care?

I am looking for some measure of their importance over, say, the last half century. We are pretty well aware in this committee that what we think of as medicine today is, what, 60 years old, 70 years old? It really begins with penicillin and sulfa. Penicillin became available in hospitals in the 1930's, but not in large quantities. It was, of course, developed in Britain.

You get phenomena such as that little pharmaceutical—there are several, but Glaxo makes one—that have cut the number of stomach operations substantially. Dr. McClellan?

Dr. MCCLELLAN. A lot.

Senator MOYNIHAN. A lot. It is just what happened, boom, suddenly.

Is there some metric we can develop about how much more central pharmaceuticals are to medical care than they had been?

Dr. NICHOLS. I can offer a metric, Senator. I do not know the exact numbers. But one simple metric is the fraction of spending that is devoted to prescription drugs, and that has doubled in the last 15 years and it is growing. It is the single fastest-growing component in all health care sectors, both the employed sector as the Medicare sector and Medicaid.

Karen may be able to speak to specific proportions of different populations, but I think that is the metric you are looking for, what fraction of costs are devoted to drugs.

Senator MOYNIHAN. Yes. But what fraction of good comes from or results, as Senator Baucus said? Who knows this? Who is going to get it for us? We have been talking about this for 15 years.

Ms. IGNAGNI. I think Dr. Nichols is right. You cannot only look at the aggregate numbers. He is absolutely right in making that point.

What I think needs to be done, is a thorough look at the chronic diseases that are facing the elderly population and to what extent prescription drugs plays a role in those.

You can take diabetes, you can take asthma, you can take congestive heart failure, you can take cancer, and we can go right down the line, and I have just mentioned a few. But if the axiom that 80 percent of the cost is consumed by 15 percent of the population as a general benchmark——

Senator MOYNIHAN. Eighty percent.

Ms. IGNAGNI. It depends on the population, it depends on the area of the country. But, in general, that is a fair benchmark. Then you can look at the chronic diseases that are responsible for that resource allocation and begin to make some judgments about the importance of prescription drugs in that context.

At the same time, I will say, from the health plan community, this is why it is very important for the committee to have a broad discussion about how to begin to do this, and where you want to go. Dr. Nichols is absolutely right, you need to look at the resources, you need to look at what you will have to allocate here, and then the question is how best to allocate.

Even you want to try to get everyone in, and that is where some individuals have focused their emphasis, you have to target more resources to those who are most in need.

I am not sure you are going to be able to cover everything, so that is why I think that is a productive discussion. Where you segment that population is up to you, and there are many ways to do it. However, it would be irresponsible not to raise the resource allocation issue, I think.

Senator MOYNIHAN. All right. I do not want to harass anyone, but it would be interesting to get more numbers on this.

Ms. IGNAGNI. We would be delighted, if the committee would find that useful.

Senator MOYNIHAN. We would.

Ms. IGNAGNI. Right.

Senator MOYNIHAN. We just got a 100th anniversary issue of the Merck manual, with a big emphasis at the time on their new product, cocaine which they thought was going to solve just about ev-

erything. I do believe Sigmund Freud's first publication was "Uber Cocaine." He used cocaine to treat the problem of morphine addiction. [Laughter.]

So just being a little contrary, how much of the longevity we have witnessed today is a result of medicine, and how much is the result of clean water? Clean water comes out ahead.

Dr. NICHOLS. Oh, sure.

Senator MOYNIHAN. Thank you. But if anybody has any ideas, do not hesitate to call us up.

Dr. MUELLER. I would just offer a couple of suggestions. I think the challenge needs to go out to the pharmaceutical industry and others who do a lot of the research work for this, and to tell us more about the cost effectiveness of a lot of the new and recent medications so that we know when it is substituting for a more costly or a form of care that might be more detrimental to quality of life.

I know I have seen such studies start to emerge now in the literature, but it is still a relatively new field of work—it is at our medical center as well—to look at the pharmacoeconomics rather than just the efficacy of the medication.

Also, to think about when it is a medical matter that is being addressed as opposed to what is a legitimate quality of life issue but may not be related to medical care.

Senator MOYNIHAN. Good. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Next, we have Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman.

Dr. Mueller, you may have heard me when I was here earlier address the problems of rural access. As you look at these plans, basically, the Breaux-Frist and the President's, your judgment as to how well rural Americans will be served by managed care under either of the two, you know that in many States there is not any Medicare managed care, what do you think?

Dr. MUELLER. I think we need to broaden the terminology a little bit and talk about more managed competition or competing health plans. To the extent that moving in that direction strengthens the underlying program, the government-sponsored program so that prescription benefits are now available, let us say, through that program, and to the extent to which—and there has been a lot of discussion here today—the premium charged to the beneficiary is held harmless versus status quo, whether that is because it is 12 percent of the government-sponsored plan or it is the government rate now, seniors in rural areas would benefit from that.

Senator BAUCUS. What, from the status quo?

Dr. MUELLER. From an improved status quo as part of an overall approach to try to generate competition among plans.

Rural areas might also benefit if plans saw the rural area as part of a much larger service area. I was thinking earlier, if you looked at the Dartmouth Health Atlas, for example, parts of my State are included in the Denver service area and the efficiencies in savings for the health plan would come out of how they pay the specialists in Denver and not how they pay the primary care physician in Chadran. The same could be true for service areas in your State

that are part of a large service area where the high cost tertiary care is concentrated.

That is where the cost savings come. I think we need to back away from the mentality that a lot of health plans have had as they first start thinking about rural, that they have to go out and get discounts off of charges from rural providers. That is not really where the savings come. The savings come at the services that are actually delivered out of the urban areas.

Finally, we would need to look at the structure for payment. In your State, for example, the plan in Billings, MO, the Yellowstone plan, has said that with a better payment structure for the managed care offering that they had for a while, they would have been able to stay in the business of providing that to the seniors in their area. That is one of the plans, as you know, that withdrew on January 1 of 2000. There is a similar plan in Bend, OR that is able to stay in, but barely at a break-even point.

Part of that, it is my idea in the testimony, of having an initial increase in payment to handle what is a spike in demand that occurs in an area where there was not full utilization of services before.

Senator BAUCUS. Part of the problem, and this may sound a bit self-serving, but a lot of these sparsely populated areas, the doctors and hospitals have been good in the sense of providing good treatment, but also not overcharging. There is an ethic that is a little different.

Now they are being penalized, in a certain sense, whether there are geographic indices or some other indices which are based upon historical performance. That is particularly true the more rural the State is, because the distances are even greater. I mean, there is rural and there is rural.

I remember, the First Lady once came to Montana not too long ago and she got off the plane and said, this is not rural, this is mega-rural. This is hyper-rural. I mean, west of the 100th meridian, rural has a completely different definition of east 100th meridian. It does not rain west of the 100th, therefore, the spaces are just mammoth.

So I am having a hard time seeing how a managed care company is going to come in and provide greater access, or however you define it, to a lot of these folks who just do not get a lot of care, as it is, today.

Ms. IGNAGNI. Senator, I think that where we go wrong, is we always have a discussion about rural health in the context of the assertion that the health plans do not want to go there.

I actually have spent a lot of time, since I have heard this so much, going out and talking to health plans who do very much want to be in the rural areas.

The single most important response that I see back from the health plans is that, although they would like to be there in many circumstances, many single-area provider systems do not have any incentive to contract with them, do not want to contract because they do not have to. There is not that kind of competition.

I think we have a lot to do on both sides, so let me just respectfully suggest that it is not simply a matter of level of reimbursement. There are some other issues here.

That is why our thought is, preserve a safety net of having at least fee-for-service as a choice for all beneficiaries on the same basis as you have today. But that is not necessarily outside of the context of a competitive proposal.

That is where we part company with the administration, which is thinking about it outside. We think you can accomplish that objective, but also put it inside the context so that you get to a level playing field and the kind of architecture.

Senator BAUCUS. Yes. I appreciate that. I think these plans are going largely in the right direction, and significantly in the right direction, because obviously we need more competition. There is too much regulation, it is clear.

Ms. IGNAGNI. I agree with you.

Senator BAUCUS. But another question goes to the specialty payments, like sole community providers and critical access hospitals, of which there are many in kind of more rural areas.

Ms. IGNAGNI. Right.

Senator BAUCUS. Do these plans provide for continued special payments to those categories?

Ms. IGNAGNI. If you are running a health plan today and you want to provide services in a local market, it would not make any sense whatsoever to ignore or walk away from the provider-based system that is the hallmark of that community. There is probably only one if we are talking about a rural area.

That is why I have really made it my business to find out a little bit more about, well, why can we not get these contracts? I found some things that I did not expect, actually.

So it suggests to me that we have a lot of work to do, broadly, and having the kinds of choices of delivery systems would accommodate both the principal beneficiary choice, not forcing providers into it, because that is ultimately what you would have to do in certain local areas. I do not think we are ready to do that, but having the choices would allow beneficiaries a little more leverage moving among various systems.

Senator BAUCUS. Yes. Your reaction, Dr. Mueller, about special payments?

Dr. MUELLER. I think they have to be continued, as I said in my written testimony. We cannot discontinue those. Again, it goes to this fundamental point. As you mention, the pricing structure is already very low in those areas and there is no reason to try to discount that steeper in order to squeeze out a few dollars in savings.

I think Karen is right, that plans ought not to want to do that. Unfortunately, we have had a few that have in some rural areas. I do not think it is a costly venture to say, keep those payments at least at the point where they are in all those special payment categories.

Senator BAUCUS. I am sorry, Mr. Chairman. Just one question.

How do these plans deal with prescription drugs? I mean, I keep talking about my State, but I happen to represent my State, and make sure my people are in on the deal here. Seventy percent of Montanans take Medigap to supplement, among other things, prescription drug coverage, and about half of the people in my State lack any significant coverage.

How are these plans going to deal with that? I came in late in the earlier discussion how drugs, it is true, are just taking over in many ways. But how do these plans deal with drugs?

Ms. IGNAGNI. I think we have to admit the issue and put it on the table, that we need to have additional resources going into the system in the area of prescription drugs. We have inched toward updating the Medicare benefit package, made important changes and contributions, but still, there is this matter of prescription drug coverage.

From a health plan perspective, the single most important thing we feel we have accomplished is to integrate the services, provide coordination, and prescription drugs is a major part of that. That is why there has been such concern in the health plan community with what has been going on as a result of the Balanced Budget Act—unintended consequences, I might say, of the Balanced Budget Act. The last thing the plans have wanted to do is make cutbacks in these important areas.

So you are quite right, we have to fund it. Then the question is, how much do you have to work with, and where do you target your funds if you get into that sort of discussion if you cannot provide it all for everyone?

Senator BAUCUS. All right. Thank you.

The CHAIRMAN. Senator Graham?

Senator GRAHAM. Dr. Nichols, you referred to your experience on the Competitive Commission. From that experience, and particularly in light of the two principles that you said you had gleaned from the 1999 retreats from competition, what would you suggest should be in any forward-moving proposals for competition to avoid a repetition of what happened last year to previous competitive efforts?

Dr. NICHOLS. Senator, I am glad you asked that question. I think it is something we should definitely engage in. Among a number of people, I know you were one of the few who spoke out against that midnight strike that stopped this thing in the appropriations process.

I think there are a couple of lessons that are fairly straightforward. One, is we have to understand that people right now are getting a very different package from the Medicare program. We think of it as a uniform program but, in fact, it is not. We have to take that status quo into account.

My simple way of thinking about that, is it seemed to me what beneficiaries were most worried about was losing their prescription drug coverage, for all the reasons we have talked about today.

What plans are worried about, is having to compete without fee-for-service competing and losing the ability to offer that prescription drug at a discounted price. I think they were legitimately worried about that.

So I think the solution is drugs. The solution is to put drugs into the benefit package. As Karen said, put public resources into that.

I would offer the possibility that, if you structure the competitive situation among health plans appropriately, that reduced growth in costs over time could end up paying for a large fraction, if not all, of that extra public cost for those drugs, but you have got to put

money in first to buy acquiescence to moving to the new reform. I would say that was certainly the most important technical lesson.

A political lesson we learned, was there was nowhere near enough conversation between the members of the CPAC and the fact that we were a creature of Congress. We were being portrayed as simply another arm of HCFA, another set of bureaucrats run amuck, and we were nowhere near that.

We were appointed by the Secretary, with your assent, and we were functioning pursuant to the Balanced Budget Act, and yet we were being characterized as this alien force. So, I think it is probably useful to have the commissioners engage with Congressmen before you get this amendment attached in the dark of night.

Senator GRAHAM. One of the central political issues in the debate over prescription medication is whether that additional benefit can just be added to the current Medicare program or whether it needs to be added as part of a larger reform effort.

That is both a medical question, are there changes in the program that are required in order to medically integrate prescription medication into Medicare, and it is also a political question, and that is, prescription medication is the engine, and once it is utilized and once it has been provided, what is the momentum to support any other reforms in the Medicare program?

So my question of each of you would be, do you believe that prescription medication should be done as a singular event or only as part of some reform effort? And if the latter, what would be your package of reforms that you would feel to be a necessary corollary to the provision of prescription medication?

Do you want to go first?

Ms. IGNAGNI. I would be happy to. We believe that you could approach this in two different ways, but they are very related. One, is that you have to think about where you are going to appropriately design the prescription drug package.

If you have the prescription drug conversation in a vacuum without looking at what you want to do systemically with the Medicare program and what is the best solution in the long term for beneficiaries, then I think you are likely to do something that fights moving in that reform direction, point number one.

Point number two. I do believe, Senator, that there is a way this year, in a way there has not been in many, many years, to have the conversation about prescription drugs. We need to think about integrating it into the benefit package appropriately, to target assistance, the most assistance toward the people who are most in need. At the same time we need to recognize that there is a problem with the private sector side of Medicare right now that we cannot ignore if we are going to move in this direction, either fulfilling the objectives in prescription drugs or thinking about that in the context of overall reform.

So I think that you need to focus on, also, what needs to be done to stabilize Medicare+Choice to allow you to have the appropriate platform to move forward. At the same time, we need to think about appropriately providing other kinds of competitive options so beneficiaries can have the maximum amount of choice, keeping the option of fee-for-service as a safety net for them so that we are transitioning towards something. You are using prescription drugs

to do it, you are not disrupting, wholly, millions of people. I think that that is the kind of confidence they are looking for.

What I do not think is the right thing to do, is to think about preserving fee-for-service here and looking at the private sector choice program over here, not drawing and connecting the dots, and thinking that we are going to continue to focus down on the private sector, get some kind of competition, and ultimately that will carry over to fee-for-service. That has not worked, it is not going to work; Dr. Nichols is absolutely right. That was the consensus of the provider and health plan community in the context of CPAC.

So there is an opening. I think it can be done very productively, I think it can be done bipartisanly, and I think it can be a major step toward the development of a reformed Medicare program in a way that assures beneficiaries of that security promise that was made in 1965.

Senator GRAHAM. This is for a yes or no answer. Do you believe that you can add prescription medication as a singular event as opposed to adding it as part of a larger reform?

Ms. IGNAGNI. I think you could do it as a singular event if you did some other things with it, and I hope it was helpful to describe some of those things. You cannot not fix what is going on in the Medicare+Choice program.

I know perhaps you would like me to give you a short answer, but what we have learned, is we have gotten into the problems we have had right now, with all due respect, because of short answers.

So I just felt it was responsible to describe what are the systematic problems that need to be addressed to achieve the objective, either short term or long term, that I think you have in mind.

Senator GRAHAM. Dr. Mueller, do you want to respond?

The CHAIRMAN. I would ask both of you to be brief, because the hour is growing late.

Dr. MUELLER. My short answer is also, yes, of course you could add it, but I agree that you would not necessarily achieve objectives. I come at this from the beneficiary's point of view in terms of, what would give me financial access to the best health care insurance program that I need as a beneficiary.

I think that requires looking not just at prescription drugs, that is the high-cost item of today, but looking at other cost items in health care delivery for the elderly that are related to chronic conditions, that might be related to eye care, dental care, and so on as a complete package, and then look at how to finance that package.

Dr. NICHOLS. Yes. You have to be careful with what you do with it. What you want to do, is make sure that the way you add it does not foreclose the competitive options you want to bring about. It seems to me that is perfectly doable in the context of where you are because these programs are actually so close together.

Senator GRAHAM. Thank you.

The CHAIRMAN. Well, thank you very much for being here today. We will have considerably more discussions, I am sure, with you. We appreciate your contribution.

The committee is in recess.

[Whereupon, at 12:32 p.m., the hearing was concluded.]

APPENDIX

Additional Material Submitted for the Record

Prepared Statement of Hon. Karen Ignagni

I. INTRODUCTION

Good morning, Mr. Chairman and members of the Committee, I am Karen Ignagni, President and Chief Executive Officer of the American Association of Health Plans (AAHP). The members of AAHP appreciate the opportunity to testify today and assist in the Committee's deliberations on proposals to reform Medicare. AAHP represents more than 1,000 HMOs, PPOs, and similar network health plans; our membership includes the majority of Medicare+Choice organizations, which collectively serve more than 75 percent of beneficiaries in the Medicare+Choice program. Together, AAHP member plans provide care for more than 150 million Americans nationwide and have strongly supported efforts to modernize Medicare and give beneficiaries the same health care choices that are available to working Americans.

In creating the Medicare program more than thirty years ago, our nation made a commitment not only to the beneficiaries who directly benefit from the program, but also to their families who otherwise would have to find ways to meet the sometimes overwhelming costs of their health care. Since Medicare's inception, Congress has taken steps to incorporate additional benefits, such as preventive services, into the Medicare benefits package and to ensure the program's solvency. The most recent effort toward this end occurred just over two years ago when Congress approved the Balanced Budget Act of 1997 (BBA).

The experience of recent years has shown, however, that incremental changes will not be enough to guarantee that Medicare continues to meet beneficiaries' health care needs and maintains a strong financial position well into the next century. Simply stated, the time has come to reaffirm the commitment made over three decades ago, and in so doing, to transform Medicare into a program that better reflects our nation's progress in improving the organization, delivery, and quality of health care services.

We appreciate this opportunity to share with the Committee our comments on reforming Medicare for future generations of beneficiaries and will comment on specific topics, including:

- Stabilization of the Medicare+Choice program to ensure a strong foundation for Medicare reform.
- Medicare reform.
- Comments on specific reform proposals, including:
  - S. 1895, the Medicare Preservation and Improvement Act, sponsored by Senators Breaux and Frist.
  - The Administration's Competitive Defined Benefit Proposal.
- Expanding prescription drug coverage.

II. STABILIZATION OF THE MEDICARE+CHOICE PROGRAM TO ENSURE A STRONG FOUNDATION FOR MEDICARE REFORM

AAHP's member plans have had a longstanding commitment to Medicare and to the mission of providing beneficiaries high-quality, comprehensive services and lower out-of-pocket costs. Many of our member plans have served beneficiaries since the inception of the Medicare HMO program fifteen years ago, if not before, when the program was offered as a demonstration project. In establishing the Medicare HMO program, Congress and the Administration were seeking to offer beneficiaries more coverage choices choices through which plans could offer beneficiaries addi-

tional benefits not available in fee-for-service (FFS) Medicare in exchange for a selective provider panel. This program was viewed as a milestone, holding both opportunities and challenges for the government, health plans, and beneficiaries. Over time, the number of Medicare HMOs steadily increased, reaching 346 in December 1998. More than 17 percent or 6.2 million beneficiaries have voluntarily chosen a Medicare+Choice plan over FFS Medicare, up from six percent six years ago.

With the passage of the BBA, Congress took significant steps toward the goals of (1) providing Medicare beneficiaries with expanded choices similar to those available in the private sector, and (2) extending the solvency of the Medicare Trust Fund. AAHP supported the establishment of the Medicare+Choice program, which was regarded as the foundation for moving forward with a program design that can be sustained far into the future.

However, the promise made to beneficiaries in the BBA of a stable program that offered a wide array of choices has yet to be fulfilled. Unintended consequences of the BBA have resulted in beneficiaries losing benefits and, in many instances, the option of even remaining in the plan of their choice. Since enactment of the BBA, nearly 700,000 beneficiaries had their Medicare+Choice coverage disrupted. Particularly hard hit by the loss of plans and benefits have been lower income beneficiaries. Health plans have offered strong value to Medicare beneficiaries, particularly those with lower incomes. A 1997 survey of Medicare beneficiaries in Arizona, California, Florida, and Texas found that 55 percent of enrollees had incomes of $30,000 or less, compared with 40 percent of such enrollees in FFS Medicare. Moreover, an AAHP analysis shows that Medicare HMOs play an important role in providing coverage to beneficiaries who receive no third party assistance in purchasing supplemental coverage.

Last year, this Congress, in passing the Balanced Budget Refinement Act of 1999 (BBRA), took the first steps to correct the BBA's unintended consequences. The phase-in of HCFA's risk adjuster was slowed and beneficiary information campaign user fees were fairly apportioned, among other changes. As the reform debate progresses, however, we must keep in mind that we cannot reach the goal of reform without further stabilizing the current delivery system. The current Medicare+Choice program is not operating for beneficiaries as Congress envisioned at its creation a couple of years ago and much work remains to stabilize the program. Under the current payment formula, plans have not been able to expand their service areas and the additional benefits, such as prescription drug coverage, that beneficiaries receive have continued to erode. While Medicare clearly needs reform, failure to build on a stable base could make this goal elusive.

III. MEDICARE REFORM

We commend the Committee for beginning its work on how to protect and preserve the Medicare program for future generations. The premium support approach examined by the National Bipartisan Commission on the Future of Medicare, as well as the Administration's proposal to increase competition within the system, are important starting points for examining how to ensure that (1) Medicare can be sustained into the future, (2) beneficiaries have the ability to choose the delivery system that best meets their needs, and (3) costs remain under control.

Achieving these objectives will raise a number of important design issues that should be carefully considered. To that end, as the Committee considers policy alternatives, what has occurred in the Medicare+Choice program offers a number of important lessons. In 1997, virtually all stakeholders supported the concept of expanding choice, but have been disappointed because of the unintended problems encountered in implementing Congress' intent. In light of this experience, our members have developed the following principles for your consideration.

- Expand Choices for Beneficiaries: Ensuring a strong Medicare program requires offering beneficiaries an expanded range of options. Consumers in the private sector have benefited from the widespread availability of health plan options, which has promoted access to affordable, comprehensive coverage. Congress endorsed the principle of expanded choice in creating the Medicare+Choice program in the Balanced Budget Act of 1997 (BBA), which in addition to health maintenance organizations and point-of-service plans that participated under the Medicare risk program, permits provider-sponsored organizations, preferred provider networks, and private fee-for-service plans to offer Medicare coverage to beneficiaries.

  Expanded choice will be rendered meaningless, however, unless these choices are affordable to beneficiaries. Any Medicare reform proposal, including premium support, should seek to ensure that the coverage options from which

beneficiaries can choose include some options that cost beneficiaries no more than options available under the current Medicare program.

- Include All Aspects of Medicare In Reform Proposal: Although more than 6 million beneficiaries have chosen to enroll in a Medicare+Choice plan rather than in fee-for-service (FFS) Medicare, while 32 million remain in FFS Medicare. No serious proposal can proceed without including this aspect of Medicare. Creating equivalent rules for all Medicare delivery options will allow beneficiaries broad choice within a consistent set of performance standards, thus preserving the program's original philosophy of universality.
- Promote Greater Choice For Beneficiaries By Permitting Flexibility in Benefit Design: All options should offer a core set of benefits. Health plans offer beneficiaries a choice of additional benefits, such as prescription drugs and lower cost sharing in exchange for a selective provider panel. Any Medicare reform proposal, including premium support, should recognize that granting plans benefit flexibility enables them to design additional benefits and to structure cost-sharing requirements in a manner that maximizes beneficiaries' coverage choices and that allows plans to provide benefits that coincide with the level of government payment.
- Provide Government Contribution that Adequately Funds Choice: Determining the amount of the government contribution will be a critical decision in the design on any Medicare reform proposal. The level of the government's contribution should be a fixed proportion of an amount necessary to adequately meet the costs of covering Medicare beneficiaries. This amount should be sufficient to allow individuals to have a reasonable level of choice among plans within an area and to ensure that choices remain available and stable over time. Additionally, the contribution amount should preserve choices available in currently successful markets and support expansion of choices in the rest of the country.
- Develop an Improved Regulatory Framework: Health plans and other options participating in a reformed Medicare program should be administered under a new framework designed to achieve a fair and sound balance between the need for regulatory oversight and the promotion of quality health care for all Medicare beneficiaries. The new framework should seek to minimize the potentially conflicting objectives evident under HCFA's current roles as a purchaser, regulator, and competitor.

IV. COMMENTS ON SPECIFIC REFORM PROPOSALS

As the Committee examines specific proposals for reform, AAHP would like to offer the Committee comments on two existing proposals S. 1895, The Medicare Preservation and Improvement Act, and the Administration's Competitive Defined Benefit Proposal.

S. 1895, The Medicare Preservation and Improvement Act

S. 1895, the Medicare Preservation and Improvement Act, sponsored by Senators Breaux, Frist, and Kerrey, among others, offers a number of interesting features for beneficiaries and other stakeholders in the Medicare program, incorporating many of the principles discussed by the Bipartisan Commission. The legislation presents a framework for bringing beneficiaries better value by injecting competition into all sectors of the Medicare program and making the regulatory structure more responsive. Further, Breaux-Frist lays a foundation to expand and maintain beneficiary choice by making payment for both Medicare+Choice plans and FFS more equitable, and allowing plans some room for creativity in benefit design within a range of the actuarial value of Medicare FFS spending.

AAHP and its member plans look forward to working with the Congress, the Administration, and beneficiary and provider groups to find the best way to achieve further specificity on several of the reforms proposed in Breaux-Frist. Among them are:

- Payment Areas: Breaux-Frist states that payment will vary geographically. Beneficiary care in the Medicare program could depend on precise details of this policy. Geographic payment adjustments should be made to ensure the Medicare program will be viable in all areas of the country in the short and long term.
- Risk Adjustment: AAHP has long supported the concept of appropriate payment in Medicare. A risk adjustment design in any new program deserves careful attention to avoid distorting payment or creating inappropriate incentives. The current system for risk adjustment, based only on beneficiaries' hospital admissions of longer than two days is not an accurate measure of beneficiaries' health needs.
- The Nature of Competition: The legislation would radically change the Medicare program by having FFS Medicare compete directly with Medicare+Choice pro-

grams to attract beneficiary business. Currently, the FFS sector represents over 80 percent of all Medicare business and will need to remain an option for beneficiaries into the foreseeable future. Thus, while preserving FFS as an option will be important for policymakers, it is equally important to put in place appropriate incentives to encourage participation by beneficiaries in private sector delivery systems in order to establish fair competition among all types of plans

The Administration's Competitive Defined Benefit Proposal

The Administration's Competitive Defined Benefit Proposal also would represent a significant departure from the current payment method under the Medicare+Choice program and has numerous implications for participating health plans, enrollees, and the government. The following summarizes key issues identified to date, based on the available information on the Administration's proposal.

- Payment may not be consistent over time: Under the Administration's proposal, payment may continue to erode relative to current levels, notwithstanding the option for payment to reflect a percentage of local costs. The 96 percent of FFS contribution would not include FFS costs attributable to graduate medical education and disproportionate share hospital payments. In fact, it is possible that payment would not be adequate to cover Medicare FFS cost-sharing.
- Non-Part D enrollees will not be subsidized: Under the Administration's proposal, beneficiaries will have a one-time option to elect the Medicare Part D prescription drug benefit. Payments to health plans for beneficiaries who do not enroll in Medicare Part D will not reflect the government subsidy for prescription drugs. Since health plans enroll a large share of lower-income beneficiaries, who may be less likely to elect Part D when they are first eligible, plans may cover a large number of individuals for whom there is no initial prescription drug subsidy. AAHP urges that there be incentives for enrollees to select prescription drug coverage when it is first offered and examinations of methods to ensure that subsequent enrollment is also appropriately subsidized.
- Current prescription drug benefits could erode: At present, approximately 90 percent of Medicare+Choice enrollees have prescription drug coverage. The Administration's rules on benefit package design require plans to use savings to reduce beneficiaries' Part B premium and cost-sharing before they could offer additional benefits, such as prescription drugs. This requirement, along with the possible lack of a prescription drug subsidy for many health plan members, and the proposal's overall payment rules, have the serious potential to decrease the percentage of enrollees with prescription drug coverage.
- Regulatory structure: The Administration's proposal retains HCFA as the Medicare regulatory body. AAHP urges that any reformed Medicare program not assign the same entity the roles of both regulator and purchaser. HCFA as a purchaser, looking to offer beneficiaries the widest range of options possible, has incentives to respond to market concerns and adopt a nimble and creative approach to widening the scope of beneficiary options. By contrast, as a regulator with limited staff and resources, HCFA may have an incentive to keep innovative models of coverage from emerging in the Medicare program to which it would have to devote scarce resources.

AAHP remains committed to helping bring about meaningful reform in the Medicare program and looks forward to working with policymakers as the reform debate moves forward.

V. EXPANDING PRESCRIPTION DRUG COVERAGE

In the course of Medicare reform debate, the importance of prescription drug coverage has been highlighted. Since Medicare's inception, the role of prescription drugs in treatment regimens has become much more prominent. Prescription drug coverage is particularly crucial for elderly persons, who use four times as many prescriptions as those under age 65. Health plans participating in the Medicare+Choice program have long recognized the importance of prescription drugs in meeting their members' health care needs. In fact, almost all of the 6 million-plus beneficiaries enrolled in Medicare+Choice plans have a prescription drug benefit. Yet, as numerous studies have shown, prescription drug coverage remains elusive for millions of Medicare beneficiaries.

Our goal should be to enhance affordable coverage of prescription drugs for all beneficiaries. A prescription drug benefit should be flexible enough in its design to meet beneficiaries' needs with the same level of financial support provided regardless of the type of coverage chosen. It should be structured so that it can be sustained far into the future and so as to cause minimal disruption to current prescription drug coverage.

Our members believe the following principles can inform the Committee's work in considering proposals to cover prescription drugs:

- Enhance Coverage of and Financial Support for Prescription Drugs: Any proposal to expand prescription drug coverage should reflect Medicare's underlying philosophy of universality. All beneficiaries should have equivalent financial support for affordable prescription drug coverage. Additional financial support should be made available for those with special needs.
- Sustainable and Actuarially Sound Funding that is Equivalent Across All Funding Options: Expanding prescription drug coverage will increase total Medicare spending. The additional costs should be supported by a responsible and sustainable financing mechanism, not on a discretionary basis. Any sustainable initiative should be designed with the incentives needed for a stable private sector delivery system.
  Federal contributions should be equivalent across all coverage options. New funds dedicated to prescription drug coverage should include options that have previously provided prescription drug coverage.
- Allow Beneficiaries a Range of Options So They Can Select Coverage That Best Meets Their Needs: Any proposal should recognize various existing coverage options and other potential innovative solutions and should retain beneficiaries' ability to select the option that best meets their coverage needs.
- Meet Beneficiaries' Needs through Flexibility in Benefit Design and Effective Delivery Strategies: Flexibility in benefit design and strategies that promote the effective use of prescription drugs are critical features of effective drug coverage. Should an initiative link financing to a minimum benefit, entities that offer coverage should be allowed to structure benefits that meet or exceed this minimum according to an actuarial equivalence or similar standard. Likewise, strategies—such as formularies, generic substitution, and programs to prevent problems associated with use of multiple prescriptions—are essential to high-quality coverage for beneficiaries. Permitting flexibility in structuring coverage will promote broader choices and better care for beneficiaries.
- Minimize Disruption of Benefits Among Beneficiaries Who Currently Have Coverage By Ensuring Equity and Value in the Government's Contribution: Recent reductions in government funding have forced many Medicare+Choice plans to reduce the scope of their prescription drug benefits or to increase beneficiary cost-sharing. Stabilizing the Medicare+Choice program is crucial to prevent the further erosion of benefits and coverage choices. Although the Balanced Budget Refinement Act of 1999 (BBRA) was a good first step toward this end, much work remains to ensure that the promises made to beneficiaries with the passage of the BBA will be fulfilled.
- Preserve Access to Integrated Health Care Benefits: Health plans that offer prescription drug coverage have sought to fully integrate this benefit into other coverage that Medicare enrollees receive. For example, medication therapy is a central component of health plans' disease management programs, which coordinate the delivery of health care services to beneficiaries with chronic conditions. Any proposal should preserve health plans' abilities to incorporate prescription drugs into an integrated benefits package.

VI. LESSONS FROM PREVIOUS REFORM EFFORTS

Many issues raised by reforming Medicare around a competitive model are similar to those experienced under the controversial competitive bidding demonstration projects proposed in recent years for Baltimore and Denver, and HCFA's current efforts to implement similar demonstrations in Phoenix and Kansas City. Successful competitive pricing models in the private sector include all options available to enrollees; HCFA's competitive pricing demonstrations have not and do not include the FFS Medicare program as an option alongside health plans. Through the BBRA, Congress recognized the problems inherent in these demonstrations by delaying their implementation until the Competitive Pricing Advisory Commission conducts thorough investigations on structural changes necessary to incorporate FFS Medicare in them.

The competitive pricing demonstration projects would continue to experiment only on beneficiaries who have chosen Medicare+Choice. As currently structured, these projects will lead to benefit reductions and disruptions for providers, which explains why in every community coalitions of physicians, hospitals, health plans, employers, and beneficiaries have joined together to raise beneficiaries' concerns about these proposals. This experience provides important lessons as consideration of Medicare reform goes forward.

VII. CONCLUSION

Over the course of Medicare's 35 years, there have been a number of important lessons learned. One is that major reform must be undertaken comprehensively. We recognize that the Committee's deliberations are critical to strengthening and stabilizing Medicare now and over the long term. We have tried today to contribute to the Committee's dialogue. We stand ready to provide any further assistance as you work on the broad issue of reform and the specific questions of preserving the Medicare+Choice program as an important building block toward this objective.

We thank you for the opportunity to testify before the Committee.

PREPARED STATEMENT OF JEFF LEMIEUX

Thank you, Mr. Chairman, Senator Moynihan, Senators, for inviting me to discuss how to change Medicare's system for competition and beneficiary premiums. My name is Jeff Lemieux, and I am the senior economist for the Progressive Policy Institute (PPI). Prior to this position I worked for the Bipartisan Medicare Commission, the Congressional Budget Office, the Health Care Financing Administration (HCFA), and an economic forecasting firm then known as DRI/McGraw-Hill.

There are many good, specific reasons for creating a new Medicare, including:

- preventing Medicare from overwhelming the budget when the baby boom generation retires,
- getting Congress out of the Medicare micromanagement business and back into the oversight business,
- stabilizing Medicare's shaky platform for private plans, and
- adding essential new benefits, especially coverage for prescription drugs and protections against unlimited out-of-pocket costs.

But those valid reasons are really just symptoms of the larger issue for Medicare: The U.S. economy and the capabilities and methods of health care have changed a great deal since Medicare was designed. To maintain strong political support from all its stakeholders, including beneficiaries, taxpayers, and health care providers, I believe we should retool Medicare for the vibrant New Economy of the new century.

A NEW MEDICARE FOR THE NEW ECONOMY

The New Economy is based on research and innovation; information and empowerment; market forces; and self-adapting, self-improving, non-hierarchical organizations. Workers are being empowered to greatly improve their productivity. Well-informed consumers have gotten used to better products at lower prices. In the future, seniors and taxpayers alike, accustomed to the efficiency and transparency of other sectors of the New Economy, will demand more value from Medicare as well: better benefits, more choices, competitive premiums.

As the Balanced Budget Act and its aftermath have shown, it is very difficult for a central authority (in this case, Congress) to micro-manage a health system as vast as Medicare. So the question becomes: How can Medicare achieve better benefits at reasonable costs? The answer, I believe, is through innovative new premium schedules. Both the President's proposal and the Breaux-Frist-Kerrey proposal would use beneficiary power to create better value. The Breaux-Frist proposal also goes the next step by attempting to build a self-improving and self-managing system for Medicare, consistent with the principles of the New Economy. (Because I have studied the Breaux-Frist proposal more carefully, I will refer to that proposal in most of my comments.)

Table 1 illustrates the basic mechanics of a premium schedule. If a plan's total premium is above a certain amount, the beneficiary pays full extra cost. If a plan's total premium is below that amount, the beneficiary's premium tapers down toward zero.

Table 1. A SIMPLIFIED PREMIUM SCHEDULE

	Total Plan Premium	Beneficiary Premium
Plan A	$6000	$1600
Plan B	$5000	$600

Table 1. A SIMPLIFIED PREMIUM SCHEDULE—Continued

	Total Plan Premium	Beneficiary Premium
Plan C	$4250	$0

Notes: This illustration assumes the reference premium is $5000 and that the beneficiary premium is 12 percent of that amount. In the Breaux-Frist proposal, the reference premium is the national weighted average premium for Medicare's current benefits. Beneficiaries choosing high option plans (with drug benefits and out-of-pocket protections) would receive an additional discount of at least $200 on their premium under the Breaux-Frist proposal. Low-income beneficiaries would receive the least-cost high option plan at a $0 premium.

In a new Medicare, plans would be paid what they bid (or negotiated) as their premium. All plans, public and private, would offer a high option, with drug coverage and out-of-pocket protections. To encourage the choice of high option plans, all beneficiaries would be offered at least a $200 discount off the price of any high option plan. (Low-income beneficiaries would pay no premium for the least-cost high option plan.) At a minimum, all plans in Medicare would be required to cover the benefits they cover now, as specified in current Medicare law for Medicare +Choice plans and as approved by the Board. The importance of bids cannot be overstated. Currently, plans receive payments based on ancient formulas that may not correctly reflect the cost of patient care. When those payments are too high, plans rush in to the Medicare market. When they are too low, plans drop Medicare coverage. Either way, beneficiaries cannot count on their plans to be there forever, because a change in the law or a regulation could cause their plan to redesign or withdraw its coverage.

By contrast, the largest plans in the federal employees' health system, which uses a premium schedule like that proposed for Medicare, have been around for decades. Federal employees have the option of switching plans each year, but even more importantly, they have the option of staying with a plan they like for year after year.

THE IMPORTANCE OF PROCESS

Because we cannot know now what the best policies will be in the future, the Breaux-Frist proposal concentrates more on process-building than on detailed policymaking. It will take several years of hard work to build a new entity to supervise a fair new competitive system for Medicare, and to prepare a new, more businesslike mentality among those who will operate the government-run fee-for-service plans. To gain the political support it needs, the public must be confident that Medicare is fair, modern, responsible, and transparent. A well-designed system of reporting and transparency, with systems in place for independent evaluation and analysis and outside comment, will help health insurers, hospitals, doctors and other health providers, seniors groups, and the public and its elected representatives gain that confidence.

The new Medicare will be more likely to succeed if it is overseen by an agency committed to its success. Currently, HCFA is the referee of competition between the traditional fee-for-service plan and private plans. That creates a conflict of interest since HCFA also runs the fee-for-service plan. Under the Breaux-Frist proposal, all health plans serving Medicare beneficiaries, including the traditional fee-for-service plan and the new HCFA-sponsored high option plans, would compete under the supervision of a new entity, dubbed the Medicare Board. As the Board gained credibility and respect, it could more readily adapt Medicare to changing times without, literally, an act of Congress for every minor issue.

Both the President's proposal and the Breaux-Frist proposal emphasize improving the operations of the HCFA-run plan as a new competitive system is introduced. The Breaux-Frist plan would focus a division of HCFA solely on operating the fee-for-service plans, and would set in motion an annual planning and reporting process intended to transform HCFA from a regulatory agency into a forward-looking, businesslike organization. Congress could at any time accept or reject the legislative recommendations accompanying HCFA's plan. After a few years, however, HCFA's plan would be considered in an up-or-down vote under expedited procedures. After an additional period of time, HCFA would be allowed to implement its annual plan without legislation.

The new Medicare's planning and trust-building process could proceed in stages:

- Establish a new Medicare Board outside of HCFA to oversee the new Medicare competition and premium system. Create a Division of HCFA-Sponsored Plans within HCFA to focus on the efficient operation of the fee-for-service plans and forming HCFA-sponsored high option plans.
- Transfer administration of Medicare's current competitive system, Medicare +Choice, to the Board. Begin evaluation process for the planning reports of the Board and the Division of HCFA-Sponsored Plans. Launch the high option re-

quirement for private plans, with the additional $200 discount and, if possible, the new low-income subsidies.
- Implement the new premium schedule and competitive system. Launch the HCFA-sponsored high option plans.
- Begin expedited consideration of recommendations of Division of HCFA-sponsored plans.
- Allow the Division of HCFA-sponsored plans to implement its plan directly, after the specified review and analysis.

If, after many years, most beneficiaries were in high option plans, those plans should be made the new standard.

FIRST DO NO HARM

Medicare is so large and important that proposals to modernize it should be designed to first do no harm. In the Breaux-Frist proposal, if the new competition doesn't save much money, then Medicare's costs and beneficiaries' premiums would be determined by the government-run fee-for-service plan, just as under current law. If the new high option plans (either public or private) are slow to ramp up, then beneficiaries would have only a spotty opportunity to choose alternative plans with comprehensive benefits, just like they have now. The new premium formulas in the Breaux-Frist proposal are designed to protect taxpayers whether the proposal works well or not.

To be sure, I believe that the new Medicare will exceed expectations. I think competition will restrain both costs and beneficiary premiums compared with current law. I think there is a good chance that high option coverage will spread nationwide, and that all seniors will be able to choose from reasonably priced comprehensive plans, both public and private. I also believe that a new Medicare system, after empowering beneficiaries with new coverage options, will also help empower them with new comparative information about the quality of their health plans, doctors, and hospitals. Timely information on quality is the key to improving our entire health system, and the new Medicare could greatly spur its creation and use.

But if I'm wrong about all that, Medicare would default to its current status, limiting the risk of change. Given Medicare's importance, limiting the risk of change should be an important consideration.

Finally, the President's plan and the Breaux-Frist plan are structured to minimize any disruption to beneficiaries when their new premium systems are implemented. Ideally, beneficiaries who are happy with their current coverage and would not consider switching plans should not even notice that the new system is in place. In the long run, of course, there may be winners and losers in a competitive system. Although the results are far from guaranteed, however, it is possible that in a new Medicare everybody wins: Private health plans compete well, the government-run plans compete well, and both taxpayers and beneficiaries share in the benefits.

CONCLUSION

To sum, I believe that Medicare's sustainability and political support will rest on its ability to adapt to the New Economy. I think that beneficiary choices in a fair and competitive system, based on innovative premium schedules like those proposed by the President and Senator Breaux and his colleagues, should drive Medicare into the future. I think that building a process for continuing improvements in Medicare is even more important than getting all the detailed policy decisions just right this year. And I encourage the Committee to create a system that would "first do no harm" if economists like myself are wrong in our initial estimates and predictions.

PREPARED STATEMENT OF MARK MCCLELLAN

Thank you Mr. Chairman, Senator Moynihan, Senators of the Committee, for the opportunity to address you today about competition in Medicare, and especially about the President's proposal for competitive reform. I am a professor of Economics and of Medicine at Stanford University. From 1998-99, I served as Deputy Assistant Secretary for Economic Policy at the U.S. Treasury, where I assisted in the development of the President's proposal for competitive Medicare reform. I would like to emphasize that my comments are my own views, and do not represent those of the Administration.

I am also a practicing physician in the Department of Medicine at Stanford Hospital. Our teaching-hospital clinic treats a large population of Medicare beneficiaries with limited incomes. Hardly any of these patient visits go by without reminding

me of the importance of modernizing the Medicare program and making it more efficient.

As an economist, I fully support the reform goals of the Bipartisan Medicare Commission, the President, Senators Breaux and Frist, and many of the Senators here today. Medicare needs to become more competitive, so that it can rely less on regulation and more on innovation to increase the value of Medicare services. These goals are also supported both by the Medicare Preservation and Improvement Act, which I will refer to as the Breaux-Frist proposal, and by the President's proposal. They would both reduce regulation in favor of price competition and other modernizing reforms, modeled on the best practices of the private sector to encourage all plans in Medicare to provide high-quality benefits as efficiently as possible. Many private employees as well as Federal employees have benefitted from such competitive approaches. These reform proposals will help Medicare catch up.

As a physician responsible for the health of many Medicare beneficiaries, I am also aware of the potential risks of sudden and significant changes in the program. Medicare needs to change significantly, but for the sake of beneficiaries, must do so carefully. One way to view the President's proposal is as a safe way to begin competitive restructuring of Medicare—in particular, to implement competitive reform while continuing to guarantee that beneficiaries can enroll in the traditional Medicare plan as they do today.

PRICE COMPETITION IN MEDICARE

At least two key conditions must be met to have effective price competition among all plans in Medicare, including the traditional plan. First, private plans must be allowed to bid competitively against the traditional plan and each other, that is, to set their own total premium. Second, beneficiaries must get savings when they choose a plan that is less costly, or pay more when they choose a plan that is more costly. In other words, differences in the bids or total costs of plans must translate into differences in the premiums that beneficiaries pay. These conditions allow plans to attract beneficiaries by offering lower costs or higher quality or both.

Both the Breaux-Frist proposal and the President's proposal would allow Medicare to meet these conditions. Under both proposals, private plans are paid a total amount that they bid themselves, not a regulated price. This change in itself may encourage more plans to participate, further enhancing competition. Under both plans, the government pays for—or supports—a portion of the total payment to a plan. The beneficiary pays the difference between the total payment to a plan and the government contribution, and the this beneficiary premium is set so that beneficiaries pay less for less expensive plans, and more for more expensive plans.

Under the Breaux-Frist proposal, the government contribution is based on the average total premium of all plans. For plans that cost the same as this average amount, the government pays 88 percent and beneficiaries pay 12 percent. For plans that cost less than the average, beneficiaries keep 80 percent of the cost savings, with the remaining 20 percent going to the government. For plans that cost more than the average, beneficiaries pay 100 percent of the additional cost.

Under the President's proposal, the government contribution is based on the total cost of the traditional Medicare plan—the equivalent of the traditional plan's "bid." For private plans that cost about the same as traditional Medicare, beneficiaries would pay the same premium as for traditional Medicare. For plans that cost less, beneficiaries would keep 75 percent of the cost savings, with the remaining 25 percent going to the government. For plans that cost more, beneficiaries pay 100 percent of the additional cost.

Under this proposal, the beneficiary's payment for traditional Medicare is determined in the same way as it is today. Tying government payments to costs in traditional Medicare, rather than the average cost of all plans, is a key difference between the President's proposal and the Breaux-Frist proposal. I want to emphasize that this difference does not insulate traditional Medicare from competition. If private plans are able to provide benefits at a significantly lower cost compared to traditional Medicare, or if traditional Medicare's costs rise faster than the costs of private plans, then beneficiaries can lower their premiums by choosing the lower-cost private plans—a choice they do not have in the current system. And the government would share in these savings. If traditional Medicare does not compete effectively with private plans in keeping costs down while maintaining quality of care, beneficiaries will have a strong new financial incentive to leave traditional Medicare for the more efficient private plans. Thus, traditional Medicare faces price competition even though its premium is protected. The President's proposal, like the Breaux-Frist proposal, would reward beneficiaries for choosing the plan that is the best value.

ISSUES IN IMPLEMENTING PRICE COMPETITION

Although both proposals create price competition in Medicare, the President's proposal is likely to give a larger share of the total savings from competitive reform to beneficiaries and a smaller share to the government. This is because the traditional Medicare plan is likely to cost more than the average plan. Consequently, in the President's plan, the government would provide a higher level of support for traditional Medicare, and also a higher level of support for the premiums of private plans. Thus, the savings to beneficiaries through lower premiums are considerably larger.

The two major reform proposals illustrate that it is possible to implement competitive reform in ways that have different implications for how the savings from competition are divided between the government and beneficiaries. Under both proposals, competition is likely to reduce the total cost of Medicare to beneficiaries and the government. I understand that concerns have been raised about the possible effects of the Breaux-Frist proposal on the beneficiary premium in traditional Medicare. The proposal could be modified to address this concern without affecting its principal effect of promoting competition. For example, the maximum government contribution could be set at about 91 percent of the cost of the average plan, rather than 88 percent. This would significantly reduce the potential for an increase in the beneficiary premium in traditional Medicare compared to current law, and would also reduce beneficiary premiums in private plans. The modified proposal would still encourage just as much price competition. But it would result in more beneficiary savings and less government savings, more like the President's proposal.

In one respect, the President's proposal does not quite create a level playing field with private plans. The beneficiary premium is the same for traditional Medicare and for a private plan that costs 4 percent less than traditional Medicare. This 4 percent "discount" in payments to private plans is a reflection of current law, in which private plans receive discounted payments compared to traditional Medicare. It was presumably included in the proposal for reasons of fiscal prudence. If the discount were suddenly eliminated and beneficiaries did not respond with even more movement into the most efficient plans, then Medicare expenditures would rise. However, if competition works and a significant number of Medicare beneficiaries move into plans that cost less than traditional Medicare, Medicare spending should fall sufficiently to make it possible to reduce or eliminate this discount. This should be done as soon as practicable, to make the competitive field completely level and thus to further encourage beneficiaries to choose the highest-value plans.

At least initially, the President's proposal may be the most prudent approach to competition. About 5 out of 6 beneficiaries are enrolled in the traditional program today, and most of these beneficiaries have no experience with private Medicare plans or comparison-shopping for plans. This approach allows them the option of continuing in traditional Medicare with no risk of new premium increases, until they feel confident enough in their understanding of their new opportunities for lower premiums in more efficient private plans. My expectation is that if private plans provide as good or better benefits at a lower cost, it won't take too long before many beneficiaries feel confident enough to switch. During this initial period, the government savings from competition may be a bit smaller than if the proposed Breaux-Frist approach was used from the start. But guaranteeing beneficiary protections when the competitive system is implemented will make it more likely that competitive reform will succeed. The potential long-run benefits to the program from the success of competitive reform seem worth the sacrifice of some short-term savings, especially if reform is undertaken soon, when a financing crisis is still some time off.

GEOGRAPHIC ADJUSTMENT

A related difficult issue for price competition is the geographic adjustment of the government contribution. The problem, as you know, is that Medicare utilization and expenditures vary enormously across geographic areas. The variations are much greater than can be explained by variations in input costs.

The current absence of price competition in Medicare is probably one source of these variations. With prices set by regulation and with beneficiaries receiving little reward for choosing more efficient plans, it is perhaps not surprising that Medicare costs can remain very high in some areas. Price competition can help eliminate these variations. If traditional Medicare and some private plans in an area are providing too much care of low value, beneficiaries could move to a plan that is able to reduce the excess utilization in return for a lower premium. Over time, and perhaps not that much time, this will tend to reduce average Medicare spending in previously high-cost areas to more efficient levels.

But beneficiaries will have a financial incentive to move to low-cost private plans in high-cost areas only if such plans have lower beneficiary premiums. Traditional Medicare has one national beneficiary premium under all of the major reform proposals; in technical terms, this means that the beneficiary premium is "fully adjusted" for the large differences in traditional Medicare's cost across areas. If private plan payments are only partially adjusted for differences in the costs of plans across areas, then within high-cost areas, a private plan that is significantly more efficient than traditional Medicare may nonetheless have a higher beneficiary premium. Price competition will be undermined, because private plans that are relatively less expensive will not appear so to beneficiaries. Partial geographic adjustment of private plan premiums, alongside full geographic adjustment of premiums in traditional Medicare, may inhibit the ability of private plans to compete with Medicare in the high-cost areas where price competition is most needed.

The President's proposal uses full geographic adjustment of private plan payments to encourage competition between private plans and traditional Medicare in high-cost areas. It also includes a "hold harmless" provision for areas with below average costs. Under this provision, the geographic adjuster would be either full adjustment or current-law adjustment, whichever is more favorable to private plans in the area.

CONCLUDING REMARKS

My remarks have focused on implementing price competition as part of competitive Medicare reform. This is only one of the critical elements needed to achieve effective competition among all plans in Medicare. Also needed is continuing improvement in methods for adjusting Medicare payments based on a beneficiary's health, so that plans have just as much incentive to compete for Medicare's many chronically ill beneficiaries as for the healthy elderly. Effective competition also requires the provision of better comparative information on health plans to beneficiaries, especially better information on health plan quality, and a fair and well-run process for choosing plans.

All of these considerations suggest that competitive reform will be challenging and will take time to implement, and that it should not be expected to yield large short-term savings. Even in the long run, it should not be expected to solve Medicare's financing problems. But competitive reform can give the program new long-term strength, by allowing Medicare to use competition to help assure that beneficiaries and taxpayers are getting high value from Medicare spending, and by enabling the program to avoid the heavy reliance on regulation that has impeded its ability to adapt to a changing health care environment. The importance of providing high-value, responsive Medicare benefits will become even more critical in the future, as medical treatment possibilities continue to expand and as our population continues to age. The substantial consensus on the basic features of competitive reform that is reflected in the Breaux-Frist proposal and the President's proposal provides clear directions for giving the program long-term strength. Taking steps toward adopting these reforms soon will reduce the need for more drastic program changes in the future.

PREPARED STATEMENT OF KEITH J. MUELLER, PH.D.

Chairman Roth, members of the Committee, thank you for the opportunity to comment on how changes in the Medicare program can improve access to services for rural beneficiaries. My testimony reflects the work of the Rural Health Panel of the Rural Policy Research Institute (RUPRI),[1] and is consistent with the policy positions taken by the National Rural Health Association (NRHA). The specific words are my own.

I want to begin by commending this Committee and the authors of proposals to redesign the Medicare program. Improving Medicare to more fully achieve the goal of universal and meaningful insurance coverage for beneficiaries is an important goal for public policy. The sponsors of S. 1895, with leadership from Senators Breaux and Frist, are to be complimented for challenging current policy assumptions and forcing all of us to think of alternative possibilities. I want to extend a personal thanks to Nebraska Senators Kerrey and Hagel for their leadership in this debate. Regardless of what actions are taken, including the possibility of strengthening the Medicare program without structural change, we are now in the early stages of an incredibly important policy dialogue.

Any major changes in the Medicare program have to balance the need to keep the program fiscally sound with the policy goal of assuring our senior citizens (including ourselves) that health care services necessary to maintain an appropriate quality of

life will be affordable and available. From a rural perspective, access to benefits and services must be comparable (not equivalent) to what is available to urban beneficiaries. Achieving comparability, or equity, is a constant struggle in Medicare policy, as evidenced in the debates surrounding the Balanced Budget Act of 1997 and the subsequent Refinement Act of 1999. Proposals to reform the program, including S. 1895 and the President's proposal, will need to recognize the special problems inherent in assuring equity for rural beneficiaries, and to their credit, the authors of those proposals have recognized this imperative. This testimony is intended to strengthen those efforts, particularly in the context of the specific legislative proposal before you, S. 1895, and the President's proposal included in the FY 2001 budget document.

Before turning to specific comments, I need to state an important caveat to this testimony. In focusing on impacts of proposals on rural beneficiaries, I am setting aside for now an equally important policy objective, assuring the fiscal health of the program. Modifications to address rural concerns will have little impact on aggregate expenditures in Medicare.

AFFECTS ON BENEFICIARIES

Currently

Medicare beneficiaries in rural areas are disadvantaged vis a vis most of their urban counterparts because there are very few managed care plans available to them. Despite the best efforts of Congress to level the playing field between urban and rural areas, prospects for rural beneficiaries have not brightened since the BBA of 1997, and in many places they have dimmed because of withdrawals of health plans from rural markets. Rural beneficiaries are not, in large numbers, benefiting from retirement plans that supplement Medicare benefits, with exceptions such as in the Bend, Oregon area. In short, if there is a prototypical Medicare beneficiary to keep in mind when trying to improve this program, that person lives in a rural community.

Medigap policies that defray the costs of deductibles and copayments in the Medicare program are more accessible to rural beneficiaries than policies that include a prescription drug benefit. Plans that would include a prescription drug benefit are quite expensive.

Aspirations to Improve

The Medicare Preservation and Improvement Act of 1999 (S. 1895) replaces the current fixed payments to Medicare+Choice plans with a system of allowing plans to set their own premiums and compete for beneficiary enrollment. There is an implicit assumption that multiple plans, some of which would parallel current managed care plans that offer expanded benefits at affordable prices, would be available to all beneficiaries. The experience of the Federal Employee Health Benefits Plan (FEHBP) demonstrates that there would be choices available in most areas, but the choices in rural areas would not include managed care plans. Remote areas such as Rushville, Nebraska have not attracted managed care plans, and in such places there may even be only one national insurer that includes local providers in its panel (BCBS Service Benefit Plan in Rushville). When a plan includes a community in its service area, but none of the local providers are included in its preferred provider panel, it is not a viable option for most elderly residents of the community. In brief, competition is not coming anytime soon to such areas.

In lieu of not having competition, S. 1895 does provide a "high option" benefit in all places by requiring that the new government-sponsored Medicare plan include both a basic benefit plan and an optional high option alternative that includes prescription drugs and a stop loss provision. Given how the premium payments are determined, this high option plan, in the future, could be costly to the beneficiaries. This possibility is recognized in the legislation and provisions are made to limit beneficiary liability when only the government-sponsored plan is offered in the local area. The difficulty with this assurance, though, is that it is void if only one other plan is offered in the area, even one that has no local physicians in its panel (for example the GEHA plan in Rushville with doctors more than 20 miles away).

The President's proposal takes a similar approach, but in a context of savings for the beneficiary and the Medicare program. The savings assume competing health plans and beneficiary choices of low cost plans. Again, the experience of the FEHBP indicates this would not occur in rural areas.

In both S. 1895 and the President's proposal, the presumption of competing plans lowering premium costs for the beneficiary is not likely to prevail in rural areas, at least not without other investment in the development of rural plans.

The two plans differ on the cost of prescription drugs, because the benefits set different annual limits; $800 initially in S. 1895 and $2,000 in the President's proposal. However, the President's proposal sets a monthly premium of $26 whereas S. 1895 allows for market determination of the premium and provides at least a 25% discount from that charge for beneficiaries. The President's proposal also claims an ability to ensure beneficiaries a price discount on each prescription purchased.

If the assumption of competing plans lowering costs is true, and if the government-sponsored plan is unable to compete effectively, rural beneficiaries could eventually see increased out of pocket costs for premiums, for two reasons. First, unless the guarantee of 12% of the weighted national average premium is completely effective, beneficiaries will pay more for the government-sponsored plan. Second, since the premium for the core benefit plan is set as a single national premium, beneficiaries in low cost areas (rural) will be subsidizing those in high cost areas (urban).[2] Neither scenario would exist if beneficiaries enrolled in competing local plans, but such is highly unlikely to occur in many rural areas.

S. 1895 includes a stop loss provision, set at $2,000 on core benefits (does not include prescription drugs, as that is a benefit in addition to the core). This would lessen the need to purchase additional insurance coverage and result in savings for the beneficiary.

Suggestions for Improving the Prospects for Choice Among Plans

1. Recognize the difficulties of establishing competing insurance plans with different benefits and premiums. The assurance to beneficiaries regarding personal liability for premiums should be based on presence of competing plans using local providers, not simply any competing plan.

2. Plans most likely to be responsive to the local needs and also likely to continue are those based in local areas (such as in Bend, Oregon and Rugby, South Dakota). Starting such plans has been difficult because of initial "spikes" in utilization by beneficiaries who had previously delayed some treatments (such as cataract surgery). A potential remedy is to invest in locally based plans by allowing for an initially higher government contribution that would phase out within 18 months.

3. The government-sponsored fee-for-service plan should vary premiums by region of the country rather than having a single national premium. This approach would be more consistent with allowing the new government plan to be more competitive within the service areas of other plans, and would have the effect of more accurately pricing premiums in rural areas.

AFFECTS ON RURAL HEALTH CARE INFRASTRUCTURE

Currently

Rural health care providers have spent the past 2 years trying to cope with the payment restrictions enacted in the BBA of 1997. They were granted some relief in the Refinement Act of 1999. The difficulties that arose as a result of changes in payment for inpatient care, outpatient care, home health, skilled nursing services, payment for bad debt, payment for cases transferred to other facilities, and hospice services are evidence of the fiscal fragility of many of our essential rural providers. Medicare payment policies have dealt with this reality through special payments and through classifying certain rural providers as distinct types of providers (such as Critical Access Hospitals) for the purposes of determining payment.

Rural providers have shown interest in the new options in the Medicare+Choice program, but there have been few takers for approaches such as provider sponsored organizations (PSOs). While new capitation payments may appear to be much higher than previous Medicare spending, especially in counties using the new "floor" payment, there are costs included in the Medicare+Choice options that were not paid through Medicare fee-for-service: developing and maintaining a cash reserve, providing benefits beyond the core benefits of the Medicare program, marketing health plans, administering health plans, handling member grievances, developing quality assurance programs, and calculating the premiums to charge beneficiaries. Given those expenses, combined with experiences of some rural health plans vis a vis initial service use by beneficiaries, the enthusiasm to develop locally based Medicare+Choice plans chilled quickly.

Changes in the New Proposals

Both S. 1895 and the President's proposal would have private health plans determine payment to rural health care providers. Both also propose allowing the government-sponsored health plan to use purchasing strategies more commonly used by private health plans, including establishing preferred provider organizations and centers of excellence in the President's proposal and use of pharmacy benefit managers in both proposals. S. 1895 would put the HCFA sponsored program at risk

for offering all services within the price of its premium, creating an incentive for an aggressive business plan, which would require Congressional approval, to purchase services at the lowest possible price.

New, aggressive purchasing behavior by all health plans servicing Medicare beneficiaries could pose problems for delivery of services in rural areas, for the following reasons:

1. Provider panels may not include the local providers, forcing beneficiaries to travel further for primary care and other services and undermining the economic well being of local providers. Distances as close as 20 to 40 miles could create burdens when the elderly have difficulties securing transportation and when local terrain and climate make any travel difficult. Any further distance for routine services would be intolerable for most rural beneficiaries.
2. Providers included in a panel one year may not be included in the next. This could occur within a local community, or within a broader service area. For rural beneficiaries there is a greater likelihood of the latter.
3. Payment to providers may be reduced such that their financial future is threatened; health plans may have the "upper hand" in negotiations.
4. Current special payments and classifications of rural providers may not continue:
   - Sole Community Hospitals
   - Critical Access Hospitals
   - Rural Health Clinics
   - Federally Qualified Health Centers
   - Payment for swing beds
   - Bonus payments for physicians in underserved areas

The President's proposal creates additional risks for rural providers because it continues several of the "savings" from the BBA beyond their current time frame.

S. 1895 changes payment for health plans, which could be meaningful for rural providers and others who have considered developing plans to offer to rural beneficiaries. The legislation contains insufficient detail to assess the impact of the changes. In particular, the geographic adjustment based on the true costs of inputs could be beneficial to rural plans and hopefully therefore to providers, if it is an accurate reflection of differences that reduces current disparities and ends the effects of using an imperfect wage index in current payment formulas. The methodology for risk adjustment is also not specified in the legislation. The provision that high risk beneficiaries could be spread among health plans may not be a viable approach in rural areas where both the number of plans and the number of beneficiaries will be small. None of the plans may be able to absorb the costs of high risk beneficiaries, without additional payment.

Suggestions for Assuring Adequate Payment for Rural Providers

1. Health plans should be required to contract with local providers in remote rural areas, perhaps based on previous Medicare payments to those providers. A range of acceptable variation from historic Medicare payments could be established. Since the majority of costs are not incurred locally, this is an inexpensive assurance.
2. Health plans could be required to continue all current special payments and classifications affecting rural providers, or Medicare revenues could be used to pay special subsidies directly. Precedent for the latter approach is established in the S. 1895 provision to pay DSH payments separately.
3. The government-sponsored plan could be required to continue special payments, subsidized by the government and not reflected in health plan premiums. This levels the playing field among plans and provides for an option that could be promoted as keeping care local.
4. Government policy could set a minimum price structure below which no health plan would be able to negotiate payment to providers.
5. Medicare payment could be used to invest in locally-based health plans by offering bonus payments during the early months of enrollment of beneficiaries, offsetting the costs of initial utilization and assisting in developing reserves. The justification for doing so is that local plans are more likely to continue using local providers and contributing to the rural health infrastructure, and are more committed to service to the beneficiaries in the community.

CLOSING COMMENTS: MUCH TO DO

I have not addressed a number of specific questions that arise from a review of these proposals:

- What benefits should be included in high option plans other than prescription drugs?

- What are the costs of transition to a new system, and who should bear those costs?
- How will plans finance the carve out that pays the costs of the new Medicare Board?
- Will the new Board function appropriately to protect the interests of beneficiaries, including those living in rural areas?
- What will be the impact of greater reliance on pharmaceutical benefit managers? What will be the impact on local pharmacists in rural communities?

I described other details that will need to be addressed, including risk and geographic adjustments. And, as I said earlier, I have not addressed more general issues of concern. I want to close by pledging ongoing assistance from the Rural Health Panel of the Rural Policy Research Institute, and other rural health researchers and analysts, to this Committee as you continue considering changes to the Medicare program. Our Panel has worked extensively to examine the rural implications of Medicare+Choice, analysis of the effects of the BBA and now the BBRA, and changes in rural health care delivery related to changes in the health care marketplace. You can see some of our work on the web sites given on the title page of this testimony. Again, I commend the Committee's effort to improve the Medicare program.

ENDNOTES

[1] "A Rural Perspective on Medicare Policy: An Initial Assessment of the Premium Support Approach." P99-7. June 16, 1999. RUPRI Health Panel, Keith Mueller Principal Author. Available from RUPRI, U of Missouri, 200 Mumford Hall, Columbia, MO 65211; or in pdf format from http://www.rupri.org

[2] For detailed analysis supporting this argument, please see pages 7-8 of "A Rural Perspective on Medicare Policy: An Initial Assessment of the Premium Support Approach," June 16, 1999, RUPRI Rural Health Panel, located in Programs, Rural Health Panel at the web site: http://www.rupri.org

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Prepared Statement of Len M. Nichols*

I am honored to come before you today to discuss proposals that could enhance the role of competition in Medicare. I should like to begin by applauding you, Mr. Chairman, and the members of your committee for holding this set of hearings so early in this congressional session and election year. Your continued bipartisan leadership will be essential if we are indeed to successfully reform and strengthen the Medicare program.

I was asked to analyze the competitive implications of the health plan pricing arrangements in the two current Medicare reform proposals—which I shall call the Breaux-Frist plan and the President Clinton plan, respectively—by drawing upon my research as a health economist and policy analyst at the Urban Institute, as well as upon my experiences as a member of the Competitive Pricing Advisory Commission (CPAC). As you know, the CPAC was created by the Balanced Budget Act of 1997 and empowered to design and implement demonstration projects that would test crucial elements of competitive pricing mechanisms for Medicare + Choice plans. As you also know, the competitive bidding demonstration's implementation schedule was thwarted by a last minute amendment to the Comprehensive Appropriations Act last November, but with your help and continued support we may yet help the Medicare program learn to use market forces to serve both beneficiaries and taxpayers more effectively. I would be glad to explain more about the CPAC experience and answer any questions you or other members of the committee may have about it at any time.

Both proposals before us today are commendable. They are comprehensive, logically cohesive, and share three key features: (1) recognition of the centrality of prescription drug coverage for modern clinical practice and for modernizing the Medicare benefit package; (2) price incentives for both health plans and beneficiaries that would encourage greater efficiency; and (3) equity protections for beneficiaries with low incomes, poor health status, or who happen to live in areas with high health care costs. Combining some elements of both plans could get us very close to significant and desirable reform.

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*Principal Research Associate, The Urban Institute. The views expressed herein are the author's alone and do not necessarily reflect those of the officers, trustees, or sponsors of the Urban Institute. I am grateful to Jack Meyer, Mark McClellan, Jeff Lemieux, Marilyn Moon, John Holahan, Stu Guterman, and Steve Zuckerman for helpful conversations about this testimony, and to Joseph Llobrera for timely research assistance.

THE GOALS OF REFORM

Before getting into details, it is often useful to begin with a simple question: what do we want a reformed Medicare health plan pricing system to accomplish? I would offer five primary objectives and note that most serious proposals share them: (1) reveal the real costs of delivering high quality care in an efficient manner; (2) provide incentives for health plans to become efficient providers of high quality care; (3) provide incentives for beneficiaries to select efficient, high quality plans; (4) protect beneficiaries from the possibly harsh consequences of geographic, income, and health status differences over which they have little or no control; and (5) provide for a relatively smooth transition from the current system to the new, more efficient one. After discussing why each goal is important, I will analyze each reform proposal's likelihood of achieving these goals. I will organize that discussion around the three key elements of any pricing reform plan: benefit package and bidding process, beneficiary payment rules, and government payment rules.

A good pricing system will discover and reveal the real costs of efficiently delivered high quality care. To accomplish this, prices must be based on specific offers or bids by willing sellers in competitive markets. Administered prices, in our democracy, inevitably end up being too high because all providers would much rather be overpaid on average than forced to compete for correct prices at the margin. With the inaccurate signals of today's administered pricing system, even as reformed by the BBA, it is difficult to tell if Medicare is paying too little. Thus, to safely maintain access, Medicare tends to err on the side of paying too much. The proof of this for Medicare + Choice health plans is the fact that the vast majority still offered beneficiaries zero premium drug benefits in 1999, even after the BBA had started to reduce payment growth for most plans. These drug benefits and other supplemental services that health plans offer can only be financed out of excess government payments for the statutory benefit package.

This is not to deny that in some areas of the country Medicare still pays health plans too little to make it worthwhile for them to enter into Medicare contracts. Overpayment on average and in some places coexists with underpayment in other areas, and this coexistence is an unfortunate fact of life under administered pricing systems. The art of health policy leadership lies in restructuring the pricing system to force providers and health plans to willingly compete for Medicare business like they do for private sector business. In the private sector, competitive bidding, voluntary market negotiations, and performance (accountability) determine prices, not formulae based on government estimates of relative costs. Only when we know true costs of delivering high quality care services in each area of the country can we have a meaningful policy discussion about which services we are willing to pay for collectively.

Market-based Medicare reform will require private health plans to play major roles in reorganizing care delivery patterns and improving provider accountability. For this to occur, both beneficiaries and profits will have to flow to plans or caregiving arrangements that provide high quality care. A pricing system with improved incentives will enable these flows to occur, but to be fully successful, a system of information flows about quality of care that plans believe in and can react to will have to be created and maintained. A new Medicare health plan pricing system that ignores quality and plan plus provider accountability will never engender the high quality care delivery that Medicare beneficiaries deserve.

If efficient care delivery plans are to flourish in a reformed Medicare system, beneficiaries must also have incentives to choose them over inefficient ones. Again, both price incentives and quality information are absolutely imperative if Medicare is to reform itself. Information flows about quality of care that beneficiaries and their families come to rely upon will also have to be created and maintained. A new Medicare beneficiary pricing system that ignores quality and plan plus provider accountability will never earn or maintain the support of the American people.

Providing price incentives to beneficiaries can sometimes conflict with equity goals that must then be balanced like any policy tradeoff. Preserving equitable access to care for beneficiaries regardless of where they live, their current health status, or their income level has always been a goal of the Medicare program. This requires special subsidies for low income individuals, as well as payment rules which insulate all beneficiaries from the financial consequences of bad health status or high health service costs where they happen to live. Payments to plans, however, must be adjusted to reflect the relative health status of their enrollees and real cost differences of delivering care in different parts of the country.

Finally, good proposals for reform not only outline the new system but lay down a clear and practical path from the current one. Medicare is not starting anew, and the transition to reform must be mindful of the high level of confidence that bene-

ficiaries have in the current Medicare program, along with the anomalies, inequities, and inefficiencies that do indeed cry out for reform. One obvious way to maintain support for reform—since over 80% of Medicare beneficiaries are still in FFS today—would be to enable traditional fee-for-service (FFS) Medicare to become more efficient while minimizing the financial penalty for remaining in the traditional program during the transition to a more competitive system. There will likely always be a role, perhaps a major role, for FFS providers in any health insurance program for the elderly and disabled.

ACHIEVING THE GOALS OF REFORMS THROUGH REAL PROPOSALS

These goals are, of course, related to each other, and more than one is sometimes affected by particular policy provisions. Nevertheless I discuss them separately as much as possible in order to help clarify the similarities and differences between the Breaux-Frist and Clinton plans.

Goal # 1: Reveal the real cost of delivering high quality care efficiently.

Both proposals are based on competitive bidding by health plans, an essential first step toward cost revelation and a major improvement over today's administered formula system. However, both plans have features which would limit Medicare's ability to elicit prices that were no higher than the true cost of efficiently delivered benefit packages.

Contrary to managed competition theory and practice in the private sector, Breaux-Frist does not require health plans to bid on standardized benefit packages. It does specify a minimum actuarial value drug benefit and maximum cost sharing (stop-loss) amounts for its "high option" plans, but it allows variation in each locale above those specifications. The purpose of standard packages is to facilitate comparison shopping and to eliminate risk selection by benefit design. The Medicare Board would have the power to disapprove a benefit package that was "designed" to bring about favorable selection, but it would be much simpler for beneficiaries and the Board if all plans had to submit bids based on the same set of benefits. Standard packages also help compensate for the absence of perfect risk adjustment, which will be the reality for at least a few more years.

The national weighted average (NWA) premium under Breaux-Frist depends only on the premium required for the "core" package of benefits. This is quite similar to the concept of a price for an efficient plan. One complexity in the Breaux-Frist bidding process, however, is that if an insurer wishes to offer only the "high option" plan, as most Medicare + Choice plans do today, then the Board must determine the "core" premium for that plan. This seems to substitute bureaucratic judgment—just as HCFA does today in the ACR (adjusted community rate) process—for market signals. This "core" price is key since it helps determine the NWA. At a minimum, the combination of flexible benefits for the "high option" plan and the Board-determined "core" premium introduces noise into the market signals coming out of the bidding process. On balance, Breaux-Frist's bidding mechanism represents major progress over today's system, to be sure, but not as clean an efficiency revelation mechanism as one can imagine, either.

The Clinton plan has (almost) standard packages with its completely specified drug benefit for its high option (Part D) plan ("almost" because Clinton does allow cost sharing to be reduced as long as the additional actuarial value is less than 10% of the basic package). However, the main difficulty the Clinton plan would have eliciting the true cost of efficient plans stems from the potentially quite high reference premium in high cost areas. Since Clinton fully adjusts for geographic cost differences—including input prices and all utilization differences—in essence Clinton pegs the benchmark government payment at 96% of the current local fee for service cost level. This feature has a number of implications that will be discussed below, but for now just focus on the first goal. Clinton allows beneficiaries to pay a zero premium if the health plan they choose bids about 20% below the local FFS cost level. There are areas of this country with utilization more than 20% higher than the national average. Thus, in those areas, the beneficiaries' premium cannot possibly be reduced enough to fully reflect a plans' low cost from reducing excess utilization to zero. Therefore it is unlikely that local health plans in high cost areas—precisely where potential savings from competition are the greatest—would bid as low as their costs unless and until FFS costs fell there as well.

Both proposals treat the high option plan—with prescription drug coverage, and also stop-loss protection in the case of Breaux-Frist—as optional. This complicates comparison shopping for beneficiaries as well as the clear price signals we are trying to elicit. Both could make the "high option" plan the standard—perhaps raising the base beneficiary premium to compensate partially for the higher cost—and still allow more generous drug coverage or other benefits to be added if plans want. The

key is to force plans to bid on the same standard package, and then to reveal the true marginal cost of any extra benefits they might want to also offer. The point of adding drugs and stop loss provisions to the basic benefit package is to move beyond inefficient benefit competition and move toward price competition.

By the way, the competitive advantages from real price competition reducing the rate of growth of Medicare costs may very well pay help pay for the extra benefits in the long run. The rate of growth of Medicare costs is much more important to long run solvency than one years level of average costs. Another way of illustrating this is to note that the drug benefits in both plans would add about 15% to the actuarial cost of the Medicare package. Fifteen percent represents about three years of the 25-year average in growth in real costs per beneficiary of 5% per year. If real competition could reduce 2 percentage points off that long run growth rate, it would pay for the drug benefit in a little over 7 years.

The general point is that one can have the competitive benefits of standardized packages without dictating every jot and tittle from Washington or Baltimore. For example, in the Breaux-Frist framework, Congress could specify the actuarial value of the "standard" drug benefit and let local area stakeholders—health plans, beneficiary representatives, providers—work out the details of their standard drug benefit. This was the approach taken by the CPAC, which let the local area advisory committees work out the details of the standard drug benefit to be offered by all local plans. Local feedback suggested this was one of the most popular and productive elements of the entire competitive bidding demonstration process, for beneficiaries and plans alike came to appreciate just how confusing and heterogeneous their current drug benefits were, and correspondingly, to appreciate the virtues of benefit package clarity and simplicity. It also has the advantage of preserving continuity with the kind of drug benefit most plans had been offering in a given area.

Goal #2: Provide incentives for health plans to become efficient providers of high quality care.

This is accomplished through payment rules, where there are two general tools, carrots (advantages from low prices) and sticks (disadvantages from high prices). Breaux-Frist uses both tools, whereas Clinton uses only carrots.

The Breaux-Frist reference price—the national weighted average premium—is likely to be considerably below the current average cost of FFS Medicare in high cost areas and above the current average cost of FFS Medicare in low cost areas. Since Medicare + Choice payments under the BBA and BBRA are still tied to local FFS costs, this means that the Breaux-Frist plan would exert much greater pressure on health plans to become efficient than would the Clinton proposal. Part of the extra competitive pressure stems from their different approaches to geographic adjustment. Breaux-Frist proposes to adjust across areas for input price differences only, whereas Clinton would effectively adjust for both input prices and utilization differences. Breaux-Frist would have the additional advantage of possibly encouraging entry of managed care plans into currently low cost areas, since the NWA is likely to be higher than their current Medicare + Choice payment rates.

Clinton's higher reference price and geographic adjusters would minimize competitive pressure on private plans in high cost areas. They could gain enrollment from lowering prices, but carrots are rarely as effective as carrots plus sticks. The historical experience of private employers suggests that managed care plans will not be able to "shadow price" more expensive FFS forever, but they still might be able to for quite a while. In some very high cost areas, beneficiary premiums under Clinton would reach zero before all of the current utilization difference is eliminated. This would attenuate the incentives for plans in these areas to become as efficient as possible, unless FFS costs here declined as well. The good news is the Clinton plan includes provisions to make FFS Medicare more like a PPO, which could move it toward efficiency eventually through selective provider contracting. The bad news is there is no price pressure on FFS Medicare to become more efficient, yet its level of efficiency is the benchmark against which managed care plans would be judged.

Goal #3: Provide incentives for beneficiaries to choose efficient providers of high quality care.

Again, Breaux-Frist scores higher on these incentives as well since it uses both carrots and sticks, while the Clinton plan always holds harmless any beneficiaries who prefer FFS Medicare. That is, it is possible that Breaux-Frist could raise premiums for FFS beneficiaries in high cost areas, thus giving them strong incentives to seek out efficient private plans. Plus, the Clinton plan only gives beneficiaries 75 cents for each dollar below the FFS benchmark cost that the private health plan bids, whereas Breaux-Frist gives beneficiaries at least 80 cents and up to the full dollar depending on the level of the plan's bid vis a vis the NWA.

Goal #4: Protect beneficiaries from the consequences of geographic, income, and health status differences.

Both plans take important steps to achieve these goals. On risk adjustment, I will assume for the purposes of this testimony that they are virtually identical, since the Breaux-Frist mechanism is unspecified but the Board would be free to choose the method just developed and currently being implemented by HCFA. If a better method becomes known in the future it seems likely to be adopted by either HCFA or the Medicare Board.

Breaux-Frist has stronger protections for the lowest income beneficiaries. As long as a high option plan is available, any person with income below 135% of poverty could enroll in the lowest cost high option plan at zero cost. And beneficiaries with incomes between 135% and 150% of poverty would get a subsidy for the drug benefit between 25-50%. Above 150% of poverty, Breaux-Frist provides a 25% subsidy for prescription drugs in the high option plan chosen. Clinton subsidizes all beneficiaries for 50% of the drug benefit, and preserves current law for dual eligibles, qualified Medicare beneficiaries (QMBs), special low income beneficiaries (SLMBs), and other low income individuals. Thus, Clintons drug benefit is more generous for most beneficiaries, but the Presidents plan has no analogue to the free high option plan for those between state-determined Medicaid eligibility thresholds and 135% of poverty.

As discussed earlier, geographic adjustment is among the larger conceptual differences in the two approaches, since Clinton's adjustment is "full" and Breaux-Frist only adjusts for differences in input prices. In a way, Breaux-Frist reflects what might be called a Wennberg-esque view of clinical practice, i.e., there is one efficient standard of care, and the government should not subsidize excess utilization with no demonstrable clinical value. Clinton's approach is more agnostic about the efficient standard of care, and his structure implicitly expects any real inefficiencies in use patterns to be eroded by competitive pricings carrots over time, but maybe not to zero.

Breaux-Frist requires HCFA to bid the same amount for the FFS plan everywhere, and since the reference price is a national weighted average, beneficiaries in low use areas would pay less, on average, than beneficiaries in high use areas. By doing full cost geographic adjustment, Clinton in essence lets FFS Medicare bid based on local costs while charging beneficiaries who choose FFS the same amount everywhere, based on national average FFS cost.

A simple way to describe the differences between the plans is that Clinton balances competing objectives (incentives and equity) toward the equity end of the spectrum, while Breaux-Frist puts a larger relative weight on efficiency. Given its Wennberg-esque view of current utilization patterns, Breaux-Frist implicitly believes that real geographic differences in care delivery patterns are not more complicated than risk adjustment can account for. Breaux-Frist may be right as an analytic matter in the long run, but it could make beneficiaries, providers, and health plans in high cost areas rather unhappy to learn so very quickly. Which gets us to the last goal, a smooth transition.

Goal #5: Provide for a relatively smooth transition from the current system to the new, more efficient one

This is the dimension where the Clinton plan shines, for it is in many ways itself a perfect transition plan, since it holds FFS beneficiaries harmless while imparting gentle but real incentives for plans to become more efficient. In essence, Breaux-Frist is less patient, and the first year's NWA could introduce quite a price shock to the high cost areas of the country, which would indeed impart strong incentives but at some cost to beneficiary and plan stability in those areas. At the same time, Breaux-Frist seems more likely to improve the health plan options in low cost areas. Breaux-Frist would be less risky in the short run if risk adjustment were already perfect. Since it is not perfect yet (but it is getting better), it is probably safer for Medicare to slide toward stronger incentives over time.

Perhaps a reasonable way to proceed is to start with Clinton and then reduce the degree of geographic utilization adjustment while lowering the percentage of FFS costs that the reference price is pegged to over time. Alternatively, if Breaux-Frist is the chosen framework, a transition plan could phase in the use of the benchmark NWA in increments, like the BBA does in gradually increasing the relative weight attached to the national risk-adjusted capitation rate in the new blended payment methodology for Medicare + Choice plans. Ideally in the long run under either plan, FFS would be self-sustaining and there would be no statutory link between FFS and managed care prices. However, given imperfect risk adjustment and the strong preference for FFS on the part of many current beneficiaries, it is probably wise to move slowly to such a potentially efficient system. Nevertheless I do encourage you to con-

tinue to work on ways to move toward it and past the Clinton plan's clever but too modest incentives (in the long run).

CONCLUDING REMARKS

This statement has focused on pricing incentives because that is the core analytic issue in the proposals at hand, but as I stated in the beginning, virtually all policy observers today agree that Medicare reform cannot ignore quality. I encourage you to investigate the innovations being put in place by, e.g., General Motors and the Buyers Health Care Action Group in Minnesota. These employers are structuring price incentives for employees that are based on health plan quality performance as well as total premium and price offers from insurers and providers. Medicare can learn a great deal from cutting edge private sector employers, as the CPAC did when designing its competitive pricing demonstration projects.

Finally, it seems worth reminding ourselves that competition is not a panacea or an end in itself. Competition in any health insurance market—especially one for some of our most vulnerable citizens—must be very carefully structured, and the competing objectives of efficiency and equity must be balanced by any public program like Medicare. Still, I believe a properly structured competitive health plan market can be the Medicare program's best long run friend, serving both beneficiaries and taxpayers quite well. I applaud your quest for that balanced structure, and would be glad to answer any questions that my testimony may have provoked.

Prepared Statement of Madeleine Smith

Thank you, Mr. Chairman, Senator Moynihan, Senators, for inviting me to testify about Medicare reform under the Administration's Competitive Defined Benefit Program and the Breaux-Frist Competitive Medicare Premium System. My name is Madeleine Smith. I am a Specialist with the Congressional Research Service, where I have worked for most of the past 11 years.

There are three points that I would like to emphasize about premiums under current Medicare and reform proposals:

1. Today, all beneficiaries pay the same Part B premium;
2. The two reform proposals would allow beneficiary premiums to vary, and thus introduce greater competition into Medicare;
3. The Administration and Breaux-Frist plans vary in details of how premiums are computed, but provide similar incentives to beneficiaries to choose lower cost plans.

CURRENT SYSTEM: BENEFICIARY PREMIUMS DO NOT VARY

Under the current Medicare program, all beneficiaries pay the same Part B premium regardless of whether they receive care under traditional Medicare or elect to enroll in the Medicare+Choice (M+C) program. In the current year, the Part B premium is $45.50 per month. Again, this Part B premium does not vary-all beneficiaries pay it (except for those for whom the premium is paid by Medicaid), and it is the same regardless of where they live.

We know, however, that the costs of providing Medicare to beneficiaries vary-by where the beneficiary lives and by the beneficiary's use of services, which is tied to his or her health status. The extent of these differences in costs of care is displayed in Table 1, which shows the average estimated monthly fee-for-service (FFS) costs by state. In 1999, average costs for Parts A and B ranged from a low of $364 in Nebraska to a high of $601 in New York. For the US as a whole, the average was $520. Because the Part B premium did not vary, and was $45.50 per month in 1999 as it is today, the Part B premium represented a different share of average costs across the states, as also shown in the table. Medicare beneficiaries were paying 12.5% of the estimated FFS costs in Nebraska, while beneficiaries in Florida, Louisiana, and New York were paying 7.6% of costs. An unchanging, flat Part B premium, coupled with variable costs of care, means that beneficiaries pay different shares of the cost for the same coverage.

REFORM PROPOSALS: BENEFICIARY PREMIUMS MAY VARY

The current Medicare+Choice program fixes minimum beneficiary premiums—at the Part B premium rate—and allows benefits to vary. Both the Administration and Breaux-Frist proposals would allow beneficiary premiums to vary, with the goal of introducing more competition into the program. Under both proposals, in fact, beneficiaries would be able to choose a plan that cost them nothing: the beneficiary premium would be zero. Under the Administration proposal, plans would bid for cov-

erage of core benefits. Plans could offer supplemental benefits and charge supplemental premiums, but these would not be bundled together with traditional Medicare-covered services and premiums as they are under the M+C program today. Breaux-Frist would allow plans to offer variable benefits, which must include core benefits; premium bids would not necessarily be for a standard, core benefit package.

ADMINISTRATION PROPOSAL

The two proposals differ in the way that beneficiary premiums and government contributions to plans would be calculated. There are five things to note about the Administration's Competitive Defined Benefit Program:

1. A plan's adjusted bid(1) is compared to the average cost for traditional Medicare, with a cut-off at 96%(2) of the average;
2. If the adjusted bid is lower than 96% of the average for traditional Medicare, the beneficiary gets 75% of the savings through a reduced Part B premium, and the government retains 25% of the savings;
3. If the adjusted bid is higher than 96% of the average for traditional Medicare, the beneficiary pays the entire Part B premium plus all of the difference in costs;
4. A beneficiary who remains in traditional Medicare pays an unchanged Part B premium;
5. The government would pay half of the premium for drug coverage for all beneficiaries electing coverage, and provide additional subsidy to those with low incomes.

Table 2 uses a hypothetical example to show how the Administration proposal would work. This hypothetical example includes 8 private plans, with premiums ranging from $4,700 to $6,600 per year. Plans 7 and 8 are assumed to offer drug coverage, while the remaining private plans are assumed not to offer drug coverage. Traditional Medicare is assumed to cost $6,000, which is the projected average per capita cost. This example also assumes that there are two Medicare plans offering drug coverage, with total costs of $6,800 and $6,900, respectively. In this example, 96% of traditional Medicare is equal to $5,760, which is the cost for private plan 4. Note that the beneficiary premium for this plan, $720, is equal to the beneficiary premium for traditional Medicare. Plans with costs below $5,760 have lower beneficiary and government payments. The first two private plans have a $0 beneficiary premium. The Administration estimates that plans with costs at about 80% of the average for traditional Medicare would have a $0 beneficiary premium.

Note that the government contribution increases for plans 1 to 4. Savings from lower priced plans are divided between the beneficiary and the government, with the beneficiary getting 75% of the savings and the government getting 25%.

Plans with costs above $5,760 have the same government contribution: $5,040 for plans without drug coverage and $5,360 for plans with drug coverage. This example assumes an estimated premium for drug coverage of $26 per month for both the beneficiary and the government. It is clear from the table that beneficiaries who purchase a more expensive plan pay all of the additional costs themselves. For example, private plan 8's total cost of $6,600 is $300 more than private plan 7's total cost of $6,300, and the beneficiary premiums for these two plans differ by $300: $1,240 for private plan 8 versus $940 for private plan 7.

The table also shows an apparent anomaly in payment structure. Both private plan 6 and Medicare have costs of $6,000-both are equally efficient in delivering traditional Medicare services. Yet, under this payment structure, beneficiaries who choose private plan 6 will pay more than beneficiaries who choose traditional Medicare: $960 versus $720, respectively. This difference results from the built-in 4% difference in premiums compared: total costs for a private plan are compared to 96% of the costs of traditional Medicare. I should emphasize that factoring in the geographic and risk adjustment procedures included in the Administration's proposal would increase the complexity of the example in Table 2.

In sum, the Administration's proposal:

- Guarantees that beneficiaries remaining in traditional Medicare would pay no more than the Part B premium;
- Allows beneficiary premiums to vary-from $0, if plan costs are about 20% lower than costs of traditional Medicare, to the entire Part B premium plus the entire difference in costs between traditional Medicare and the plan, if the plan's costs exceed those of traditional Medicare.

BREAUX-FRIST PROPOSAL

I would like to turn now to an explanation of beneficiary premiums and government payments under the Breaux-Frist Competitive Medicare Premium System. As in the case of the Administration's proposal, payments may vary. Here they depend on the relationship between the plan's premium bid and the national weighted average premium. Important points to note are:

1. If the plan's premium bid is less than or equal to 85% of the national weighted average premium, the beneficiary pays $0 premium;
2. If the plan's premium bid is greater than the national weighted average premium, the beneficiary pays the complete cost of the difference between the bid and the average;
3. All beneficiaries receive premium assistance for the costs of drug coverage included in high option plans;
4. Low-income beneficiaries get additional financial assistance for costs of coverage.

Under the Breaux-Frist proposal, all plans—including the HCFA plans—submit a premium bid to the Medicare Board. The Board adjusts the premiums to represent the cost for core benefits only, that is, benefits covered under Parts A and B. The Board calculates a national weighted average premium based on plans' bids for core benefits and prior year enrollment. This process can be illustrated with the hypothetical example in Table 3, which includes 8 private plans and 3 HCFA plans. (Tables 2 and 3 were constructed to be as parallel as possible, given differences between the two proposals.) The plan's premium bids are shown in column 2, and range from $4,700 for private plan 1 to $6,900 for HCFA plan 3. Private plans 7 and 8 include drug coverage, along with HCFA plans 2 and 3. Premiums for core benefits are shown in column 3. In this hypothetical example, private plans 1 to 5 do not include any additional benefits beyond those covered under the core benefit package. Therefore, the premium for core benefits equals the original premium bid by the plan. Private plan 6 differs. It includes additional benefits beyond core benefits, which the Board determines cost $100. Consequently, the premium for core benefits for private plan 6 is $5,900 rather than $6,000. All of the high option plans, which offer drug and stop-loss coverage(3), have premiums for core benefits which are lower than the original bids.

Based on the premiums for core benefits, and enrollments in each plan, the Board calculates a national weighted average premium (NWAP). In this example, the NWAP is $5,896. To calculate beneficiary premiums and government contributions, we need to know 85% of the NWAP, which is $5,012 here. Plans with premium bids below 85% of the NWAP (i.e., $5,012) have a beneficiary premium of $0, and the government pays 100% of the plan bid. Private plans 1 and 2 fall into this category.

Both beneficiary and government contributions would increase until the plan's premium bid reaches the NWAP-$5,896 here. In this example, beneficiaries remaining in traditional Medicare would pay $811 per year, which is larger than the $720 premium under the Administration proposal. This happens because the premium for traditional Medicare is greater than the NWAP-a result that will occur if most private plans charge less for core benefits than Medicare does. The maximum government payments in this example are $5,189 for plans without drug coverage, and $5,389 for plans with drug coverage. These government contributions reflect the minimum $200 government subsidy for drug coverage which would be available to all beneficiaries who choose this coverage. This example does not account for additional assistance to those with low income, or geographic or risk adjustment which would add to the complexity. As in the case of the Administration proposal, beneficiaries who choose lower cost plans will face lower premiums. Beneficiaries who choose high cost plans will pay the entire amount of costs above a threshold.

Under the Breaux-Frist plan, no difference in beneficiary premium occurs for plans with identical premium bids such as private plan 6 and HCFA plan 1, both of which have premium bids equal to $6,000. Table 3 shows that the beneficiary pays $811, and the government pays $5,189 for both of these plans. There is no "notch" in beneficiary premiums as in the Administration proposal. This example illustrates that the government is contributing to the cost of benefits not covered under traditional Medicare, as occurs under some M+C plans today, but would not occur under the Administration proposal.

In sum, the Breaux-Frist proposal:

- Does not guarantee that beneficiaries remaining in traditional Medicare will pay an unchanged Part B premium, because all plans -HCFA and private-are subject to the same premium calculation method;
- Allows beneficiary premiums to vary-from $0, if plan costs are 15% lower than the average for all plans, to the entire Part B premium plus the entire dif-

ference in costs between the plan and the average, if the plan's costs exceed the average for all plans.

SUMMARY

Comparing these two hypothetical examples indicates that, on average, beneficiaries would pay slightly more under the Breaux-Frist plan: $899 per year, or 15% of the total, under Breaux-Frist compared to $860, or 14% of the total, under the Administration proposal. This is due to the way premiums are calculated, not anything intrinsic to the proposals. The computational formulas could easily be altered to change the results, for example by changing the 96% of average under the Administration proposal, or the 85% of the national weighted average under the Breaux-Frist proposal.

To summarize, both proposals would make significant changes to the Medicare program by allowing beneficiary premiums to vary. These changes could introduce more competition into beneficiary selection of plans. The ability of private plans to offer coverage of Medicare benefits for a $0 premium could provide incentives for many beneficiaries to choose lower cost plans, which could produce savings to the program.

The two proposals differ in their treatment of premiums for beneficiaries remaining in traditional Medicare. The Administration proposal would guarantee these beneficiaries an unchanged Part B premium. The Breaux-Frist proposal would treat traditional Medicare like all other plans, and base beneficiary premiums on the relationship between Medicare's premium and the average premium for all plans.

This concludes my testimony. I would like to thank the Committee for this opportunity to discuss these two proposals to reform Medicare.

ENDNOTES

(1) Before beneficiary premiums were calculated, bids submitted by plans would be adjusted for local variations in the costs of delivering care and for the risk of beneficiaries enrolled in the plan.

(2) The Administration estimated that managed care plans would receive about 96% of traditional Medicare costs in 2003. This 4% discount is based on the traditional 5% reduction for managed care savings, the mandatory reductions in the national M+C growth percentage of -.008 percentage points in 1998 and -.05 percent points each year from 1999 through 2002, and an approximate 4% increase due to lack of re-adjustment for overestimation of cost increases for 1997.

(3) Stop-loss, or catastrophic, coverage would limit beneficiary out-of-pocket expenditures to $2,000 in 2003. The limit would apply only to services covered under Parts A and B, and would exclude beneficiary expenditures for prescription drugs.

Table 1. Estimated Monthly Fee-for-Service Costs and Part B Premiums as a Percent of Costs, 1999

State	Avg. Cost	Premium as % of Cost	State	Avg. Cost	Premium as % of Cost
Alaska	$528	8.6%	Nevada	$533	8.5%
Delaware	538	8.5	New York	601	7.6
Florida	595	7.6	Oklahoma	448	10.2
Georgia	532	8.6	Tennessee	516	8.8
Iowa	380	12.0	Texas	527	8.6
Louisiana	596	7.6	Utah	409	11.1
Mississippi	475	9.6	Vermont	396	11.5
Montana	392	11.6	Virginia	451	10.1
North Dakota	378	12.1	West Virginia	481	9.5
Nebraska	364	12.5	U.S. Total	520	8.8

Part B Premium was $45.50 per month. Chart prepared by Congressional Research Service.

Table 2. Administration's Competitive Defined Benefit Program: Hypothetical Example of Beneficiary Premiums and Government Payments

Plan	Total cost	Percent of traditional Medicare	Enrollment	Beneficiary premium		Government contribution	
				$	% of total	$	% of total
Private 1	$4,700	78%	3%	$0	0%	$4,700	100%
Private 2	$4,800	80%	2%	$0	0%	$4,800	100%
Private 3	$5,600	93%	2%	$600	11%	$5,000	89%
Private 4	$5,760	96%	2%	$720	13%	$5,040	88%
Private 5	$5,900	98%	2%	$860	15%	$5,040	85%
Private 6	$6,000	100%	2%	$960	16%	$5,040	84%
Medicare	**$6,000**	**100%**	**62%**	**$720**	**12%**	**$5,280**	**88%**
Private 7 + drugs	$6,300	105%	3%	$940	15%	$5,360	85%
Private 8 + drugs	$6,600	110%	2%	$1,240	19%	$5,360	81%
Medicare + drugs	**$6,800**	**113%**	**10%**	**$1,440**	**21%**	**$5,360**	**79%**
Medicare + drugs	**$6,900**	**115%**	**10%**	**$1,540**	**22%**	**$5,360**	**78%**
Weighted average	$6,113	102%	100%	$860	14%	$5,253	86%

Source: Table prepared by the Congressional Research Service.

Table 3. Breaux-Frist Competitive Medicare Premium System: Hypothetical Example of Beneficiary Premiums and Government Payments

Plan	Plan's premium bid	Premium for core benefits	Enrollment	Beneficiary premium		Government contribution	
				$	% of total	$	% of total
Private 1 - standard	$4,700	$4,700	3%	$0	0%	$4,700	100%
Private 2 - standard	$4,800	$4,800	2%	$0	0%	$4,800	100%
Private 3 - standard	$5,600	$5,600	2%	$471	8%	$5,129	92%
Private 4 - standard	$5,760	$5,760	2%	$599	10%	$5,161	90%
Private 5 - standard	$5,900	$5,900	2%	$711	12%	$5,189	88%
Private 6 -standard	$6,000	$5,900	2%	$811	14%	$5,189	86%
HCFA 1 - standard	**$6,000**	**$6,000**	**62%**	**$811**	**14%**	**$5,189**	86%
Private 7 - high	$6,300	$5,400	3%	$911	14%	$5,389	86%
Private 8 - high	$6,600	$5,700	2%	$1,211	18%	$5,389	82%
HCFA 2 - high	**$6,800**	**$6,000**	**10%**	**$1,411**	**21%**	**$5,389**	79%
HCFA 3 - high	**$6,900**	**$6,000**	**10%**	**$1,511**	**22%**	**$5,389**	78%
Weighted average	$6,113	$5,896	100%	$899	15%	$5,214	85%

Source: Table prepared by the Congressional Research Service.

COMMUNICATIONS

STATEMENT OF DON R. MCCANNE, M.D., BOARD MEMBER, PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

Policy analysts and politicians alike recognize the evolving demographic changes that mandate that reforms be made in our Medicare program that will assure that funding will always be available to ensure that health care need never be an issue for the retired and for those with long term disabilities. President Clinton and Senators Breaux and Frist have advanced plans that have been accepted as the nidus for reform. Both plans propose using competition between health plans as the primary mechanism to control health care costs. To limit the discussions to such a narrow concept of reform is a glaring logistical error.

ABUNDANT HEALTH CARE RESOURCES IN AMERICA

We really do need to step back and briefly absorb a panoramic perspective of the status of health care in America.

At 14% of the Gross Domestic Product of the wealthiest nation on earth, the amount that we already delegate to health care, we have available an enormous reserve of funds, the envy of the world. We already have far more funds in health care, per capita, than all other industrialized nations, nations which provide comprehensive care for everyone. The world is also envious of our infamous excess capacity in health care. With all of this wealth, and with this great capacity, we stand in shame before our fellow nations over the fact that we have not been able to utilize this great gift for the benefit of all of us. Unfortunately, by confining thought processes to health plan competition, more effective and beneficial alternatives are being ignored.

The committee is addressing the issue of controlling Medicare costs through health plan competition. The models before them threaten to reduce benefits offered to Medicare beneficiaries, merely for the purpose of preventing the inevitable increase in funding that will be necessary to assure comprehensive care for everyone enrolled in the Medicare program. The amount of additional funds that would be necessary to fund comprehensive care for all Medicare beneficiaries pales in comparison to the amount that we would need to provide similar benefits for the entire nation under our current health care structure. We need to admit that our current system is not capable of properly allocating our generous resources to provide optimum care for everyone. We need fundamental structural reform. In the best of economic times, from a perspective that has a limited amount of time on our side, it would be a tremendous error not to address the more global issue of funding comprehensive care for everyone.

IS HEALTH PLAN COMPETITION A RATIONAL APPROACH TO COST CONTAINMENT?

Competition in the marketplace is a well-accepted business theory of controlling prices. There is serious concern about whether this theory is applicable to competition between health care plans. In health care, the legitimate market is between patient-consumers, and the actual providers of health care, including physicians, hospitals, pharmacies, laboratories, and others. Health plans have interjected themselves as intermediaries and have assumed control of the health care marketplace. They dictate to patients and providers the terms of participating in the health care market. Whether health plans really compete with each other is in some doubt as they continue their march toward monopsonistic control of the market. The current Medicare proposals place the market health plans in competition with the traditional HCFA administered program. Although the traditional program is a high cost risk pool, since it includes a higher level of chronically ill individuals, the extra costs do not begin to offset the very high administrative costs characteristic of the private

plans. In order to compete on price, the private plans, of necessity, will have to reduce the benefits available for their beneficiaries. Competition based on the ability to deprive patients of relief from suffering is not the direction in which we wish to be headed.

There are doubts about whether health plans will even be able to survive, considering their outrageous administrative costs and inefficiencies. Even now they are exiting some markets, and are shunning the same competitive models that the legislative proposals support. It would be a mistake to enact legislation that places health plans in control, only to see them exit the market once it is clear that they cannot compete. Then we could be left with a severely impaired Medicare program that might take much longer to rebuild than it would have taken to inflict the damage.

Medicare cannot be reformed as an isolated process. The health care delivery system does not isolate Medicare into a separate niche. Medicare services are delivered by the same system that delivers all health care services. As examples, changing Medicare influences cost shifting, structural design of health plans, business decisions of provider organizations that impact health care, funding of academic centers, and the viability of many sectors of the delivery system. Rather than changing our health care system to meet the political manipulations of Medicare, it would be far preferable to change our health care system into a rational, integrated system that can meet the health care needs of everyone, including Medicare beneficiaries.

The plight of the uninsured and under-insured is a much greater and more pressing problem than even the issue of assuring adequate funding of Medicare. These deficiencies are escalating in the best of times, and can only become more catastrophic at the next major downturn in our economy. The public will demand comprehensive reform. It is imperative that we abandon the view that Medicare is an isolated problem, and that we forthrightly move to rebuild our entire system to optimally serve all of us.

MODERNIZING THE TRADITIONAL FUNCTIONS OF HEALTH PLANS

If health plans are not the actual delivery system of health care, then just what do they do? Traditionally, they have three functions, administration and marketing, risk pooling, and information management. Let's look at these functions.

The functions of administration and marketing alone place into serious doubt the validity of nurturing health plans as the model for Medicare reform. The multiplicity of health care plans duplicates endlessly the administrative functions of a rational health care system. Most plans are careful to fund, first and foremost, their own administrative divisions, including the exorbitant executive compensation packages. Increasingly, venture capitalists and shareholders are drawing off more funds. Marketing, including advertising and duplicative contracting efforts directed at providers and at patient-consumers, draws off even more funds. Although health plans have been successful in attaining a one-time slowing of health care inflation by ratcheting down rates paid to providers, their own administrative costs have consumed much of those savings. In fact, the health plans themselves are the greatest inflationary element in health care today. The dollars that they are wasting should be re-directed to patient care.

Perhaps the most important traditional function of health plans is to pool risk, moderating costs such that health care remains affordable for all. Today, the behavior of health plans is to avoid risk, as they devise methods to pass risk on to patients, providers, and purchasers of health care. Perhaps the most egregious example of this behavior is their established pattern of utilizing marketing techniques to avoid enrolling higher risk individuals, even though they have been able to convince the purchasers of plans, especially the government, to fund them at levels that would cover this risk that they effectively avoid. In abandoning the function of risk pooling, health plans are providing almost no value for the outrageous amount of health care funds that they are consuming.

Information management is the key to modernizing Medicare, and, in fact, modernizing our entire health care system. At present, health plans limit information technology primarily to claims processing. Some attempt at quality assessment is being made, but this science is still in its infancy. We now have a tremendous potential for improvement of our health care system through the power of integrated information technology. Using encrypted electronic medical records as a substrate, we can coordinate care between all providers, reduce error, provide portability, and provide anonymous outcome data that can generate guidelines for improving allocation of our resources. Investigating outliers for excessive quantity, frequency or intensity of services can reduce fraud and abuse. If we are careful to be certain that the technological infrastructure is developed in the public domain, then vendors can provide

these services economically, at cost with a fair profit. The alternative is to passively allow proprietary entities to continue with their current plans to monopolize the health care information technology industry for the purpose of creating mega-wealth. Such a model would only add on to our current defective system, diverting even more dollars away from patient care.

Some features of Medicare cannot be left to the market to be manipulated by a common business ethic that is designed to enhance shareholder value. Defined, comprehensive benefits are an essential element of Medicare. Allowing business interests to deprive beneficiaries of benefits merely because of goals of cost containment is not acceptable. Pharmaceuticals have become such an integral part of care that coverage is now mandated. Beneficiaries must also be protected against catastrophic losses and excessive out-of-pocket expenses that threaten affordability and access.

We need to re-visit risk pooling. Today, the funding of Medicare is irrational. We take the most expensive risk pool, the retired and those with disabilities, and we fund that pool primarily on the backs of wage earners, 44 million of whom cannot afford insurance for themselves or their families. We need to place all funds into one single risk pool, which includes everyone, and fund that risk pool in a fair and equitable manner, such that each pays their share, based on capability. This is really the only ethical and rational method of funding our health care system.

Our antiquated health plans, as we know them, should be eliminated. We should end the outrageous waste in administrative costs and marketing, and end the drain of health care dollars to passive investors that are providing no value in health care. We should establish a single risk pool, funded in a fair manner. We should replace the middleman insurance/managed care industry with a public, integrated information technology system.

COST CONTAINMENT THROUGH GLOBAL BUDGETING—REDIRECTING DOLLARS TO PATIENT CARE

Much of the reason for discussing competition amongst health plans has been for the purpose of containing costs through the market forces of competition. If we do not have competing health plans, then how can we contain costs? Simply, we can do it by utilizing global budgeting, combined with negotiated rates for providers, and budgeting of capital improvements. Budgets are often condemned as a mechanism of containing costs, yet every business, every household, and even every health plan uses budgets. There is no rational reason that our entire health care system cannot be funded through a budget. Most other industrialized nations have been successful in establishing universal health care coverage by utilizing some form of global budgeting, resource planning, and control of rates to hospitals and physicians. Providing comprehensive services to everyone, within the limits of a very modest budget that is characteristic of all other nations, occasionally stresses the system, resulting in some delays for elective services. The crucial difference in the United States is that our great wealth and our excess capacity in health care refute fears that universal coverage would result in unacceptable queues for care. In fact, just the opposite would occur for the 44 million uninsured that would no longer be subjected to the implicit, infinite queue that they now face. A publicly administered global budget would change the paradigm from a model of micro-management of clinical services to a model of macro-management of the funds used to pay for comprehensive services.

THE MORAL IMPERATIVE

We have enough resources to provide quality care for everyone. We have a very sick system that remains incapable of delivering those resources to patients. We need to restructure that system, converting it into an efficient, integrated entity, utilizing the great power of information technology. Demographic changes and aggressive market elements have created an element of urgency. We are long overdue for the development of the political will to enact health care reform that will finally enable us to say, quite honestly and with justifiable pride, "We have the finest health care system on earth."

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